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WHAT PUBLIC HEALTH EXPECTS OF THE PRIVATE PHYSICIAN

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THE first three lectures to commemorate the leadership and inspiration of Dr. John W. Bell in the tuberculosis campaign of Hennepin County were devoted to topics so nearly akin to what you have assigned to me today, that I fear some inevitable repetition of fact or of opinion. However, since man's experience with tuberculosis has been longer than his acquaintance with either the art or science of medicine, some reiteration of ancient truths may be excused. Permit me to develop the topic in hand in part historically and further by reference to the formal requirements of contemporary sanitary law and to the current experience of your own community.

The first epidemiologist Hieronymus Fracastorius gave in his classical volume De Contagione in 1546 the first clear description of the contagion of consumption. Without the ability to see or identify the tubercle bacillus he coined the expression "seminaria of disease" and wrote "These seeds are the carriers of the contagion and that they are the first origin of the disease there can be no doubt. It may be considered that the force of the disease lies in these seeds since they have the power to propagate and reproduce their own kind."

This wise and philosophical student of the mass manifestations of communicable diseases, wasted no time on environmental, economic, social or racial factors. He found a disease of universal prevalence, the spread and continuity of which he knew to be due to the infection of the well by the sick, and he declared with a convincing simplicity that the need was "to combat germs and prevent contagion."

Down the ages this eternal truth has resounded, and those whose ears have been deaf, whom ignorance and selfishness have made blind, whose reasoning has lacked logic, have paid the penalty of sickness and death in their time.

Leaping the four centuries from Fracastorius to Frost, from Verona to Baltimore, from the era of Italian renaissance to the first fruiting of systematic epidemiology in our own country, we read the brief statements of the two conditions which limit the propagation of the tubercle bacillus: (1) "In order to escape from its host it must cause a lesion which breaks through to the surface—in general an extensive lesion which severely damages the host; (2) it succeeds in producing such lesions in only a limited proportion of infected persons."

"Other human pathogens may be subject to one or the other of these conditions but not to both."

"The combination of these two limiting conditions is the peculiarity of the tubercle bacillus which makes it more amenable to control by case isolation than are such diseases as diphtheria, scarlet fever or measles."

If we may define public health services as the application of the sciences of preventive medicine by public authority for social benefit, then the

The John W. Bell Tuberculosis Lecture delivered before the Hennepin County Medical Society, December 3, 1945.

private physician must be expected to discover the infected person, identify him by name and address to public authority, and aid in revealing the source of infection in this index case and the tracing of secondary or associated infected persons among contacts.

To follow the implications of Frost's two premises, it is only the sputum-positive cases that need to be isolated in order to prevent the spread of infection, but all clinically recognizable infected persons should be known to the health department. Furthermore, and to make our task the easier, for the eventual eradication of human tuberculosis, it requires only that the rate of transmission be held permanently below that required to carry on the succession.

If from year to year and generation to generation there is a reduction in the number of infectious hosts, the end must be extermination of the tubercle bacillus. If we but keep the present balance of a diminishing number of sources of infection, human tuberculosis will disappear. With the practical or near approach to eradication of bovine tuberculosis among dairy cattle, the infected open or positive sputum case of human tuberculosis is the only source of infection in the United States today.

In France and in most of Continental Europe there is little confidence in ultimate eradication of tuberculosis. Their experience with wars and hunger have dulled their imagination and postponed a vision of the future which to us seems vivid and near. The Frenchman clings to the philosophy of Calmette which presupposes universal exposure to the tubercle bacillus and therefore calls for universal artificial immunization.

Our experience leads us to the contrary conclusion, that tuberculosis is in the process of disappearance which can be awaited with confidence while persisting in our efforts to separate the sick from the well and reduce progressively the number of positive sputum patients at large among us.

As the moderate inoffensive alcoholic habitué is the reservoir from which the chronic alcoholic and inebriate mental derelicts are recruited, so it is the infected persons revealing no subjective or objective evidence of active pulmonary tuberculosis from whom are developed the active, progressive positive sputum patients who constitute the links in an age-old chain of infection. For administrative justice to all the people and for competent scientific epidemiology of the disease by the health department, all cases of appreciable clinical tuberculosis of any part of the body must be reported whether or not at the time the tubercle bacillus has been found in the body discharges.

As in the administrative control of typhoid fever we have passed through several evolutionary phases of method, from the general to the particular, from the broad programs of water purification, sanitary sewage disposal, and pasteurization of milk to the meticulous detective search for the carrier and the supervision of his way of life, so have we moved from popularization of personal hygiene, from mass information, to a point where nothing short of universal x-ray diagnosis will suffice for control of tuberculosis.

What shall be our immediate and future program directed not towards a remote and indefinite objective, but geared and adapted to reach a terminal point, now obviously within our reach? We must gird ourselves for the last lap, the crowning competition and reward among the states, between cities, counties and ultimately between nations. Already we see in your own state and as well in rural districts and in large cities, cases of optimum health, areas and communities among which no death from tuberculosis has occurred over a five-year period, broad population units from which the young people coming to your great University are free from tuberculous infection.

The challenge ahead is stirring. Will you let Utah, Idaho or Washington claim the distinction of being the first state without a death or a new case of clinically active tuberculosis reported within a year or a quinquennium?

It was with a distinct emotional thrill, a sense of lift and elation, that I visited recently a county of the southern tier where annual death rates from tuberculosis had averaged about 5 per hundred thousand per annum. And it was with no less interest and concern that I found a northern county so effectively busy with case finding that within two years it may be expected that every person, old and young, will have had a permanent x-ray record of the chest.

To shape our program to a certain and successful conclusion we must discard traditional generalities. Of course, we shall be concerned with nutrition, housing, working environment, length of work days, economic justice, recreational facilities, and rehabilitation of the post sanatorium patient. These are but the expressions

of an enlightened humanism but no one or all of these will materially affect the incidence of tuberculous infection or manifest tuberculous disease.

To be definite and specific we must use as direct methods as we would for smallpox or typhoid fever, granting that social assistance is worthy of support, but not at the cost of overlooking the primary role of the spreader.

All control of communicable disease begins with prompt information as to the occurrence of the disease in question in a certain person at a certain address. Verification of the diagnosis may be needed. Search for prior and subsequent cases among contacts must be prompt and complete. Each person capable of infecting others must be so controlled as to be no hazard in the community, preferably by being admitted to a tuberculosis hospital. Since tuberculosis is commonly a silent and insidious invader, reliance upon complaint of illness by the patient or diagnosis without x-ray of the chest cannot be longer tolerated. I must refrain from further repetition of such truisms long well known to official and voluntary agencies. Let me but say that nowhere is the modern program against tuberculosis better expressed than in that brief and authoritative little handbook by Henry D. Chadwick and Alton S. Pope, "The Modern Attack on Tuberculosis," obtainable for a dollar from the Commonwealth Fund. In order of importance are:

1. Isolation in sanatoria of all known open cases of pulmonary tuberculosis.
2. Good medical care preferably in institutions of known active, though not at present open, cases.
3. Systematic search for early and unrecognized cases and their isolation if discharging tubercle bacilli.
4. Social and medical protection of underprivileged groups who are endangered by tuberculosis by reason of ignorance, poverty, unemployment, hazardous occupations and crowded conditions of living.

As fewer cases are reported and discovered, open positive-sputum patients must be the main objects of control, by increasingly effective measures at home and in sanatoria.

To quote Frost again:

"As the disease becomes rarer, less a matter of everyday experience, we may be assured that public opinion will not only support but will even demand more rigid isolation."

How does this proposal for specific practical measures compare with today's performance?

One can only marvel at the favorable picture of falling mortality and reported incidence of tuberculosis in Minnesota and Hennepin County in the light of the record of reporting.

In the state of Minnesota in the period 1910 to 1940 when the tuberculosis death rate fell from 109.4 to 29.7, the percentage of deaths not previously reported as cases of the disease fell from 86 to 15.5 per cent.

It is probable that less than half of the active cases of tuberculosis have been known to the authorities at any time in the past thirty years or are today so known.

To quote from the 1922-43 report of the Minnesota State Board of Health, "In 1910 there were more than three times as many deaths from tuberculosis as there were reported cases. Tuberculosis is a reportable disease, but it has never been adequately reported."

Michigan today leads all the states in the ratio of new cases of tuberculosis reported in a year to deaths from this disease in the same period, 3.25, and yet evidence is abundant that not less than five and probably between seven and ten cases could be discovered and should be reported if the private and public resources of medicine were used to full advantage.

The citizen may well ask why! Is a requirement of the Board of Health, having the force and effect of a law, to be disregarded with impunity, and if so, who enjoys the privilege of this violation of the spirit and intent of the law? May I respond to the title of my discussion by saying that the humblest expectation of public health is that physicians recognize tuberculosis prior to the patient's death and report every person infected and receiving medical care, whether or not such patients are at the time discharging tubercle bacilli.

And now for the city of Minneapolis. In the year 1919, 16 per cent of cases of tuberculosis reported to the Division of Public Health, were reported less than one month prior to death or actually after death by declaration on the death certificate. Twenty-five years later, in 1944, 5.8 per cent of reported tuberculosis was reported within a month of death or after death, a substantial improvement. This is not, however, a creditable record and must be explained by the medical profession. Permit me to suggest now that the Hennepin County Medical Society appoint a permanent committee on tuberculosis, to

which should be referred by the Division of Health, for inquiry and periodical report to the membership of the society, each instance of a report of tuberculosis made either within a month of death or only by the death certificate.

In making special study of similar situations in Philadelphia and Boston I found in the latter city that by fifty cases of chronic pulmonary tuberculosis with intermittent positive sputum not reported until within a month of death, there had been, over a period prior to the reports of these patients to the health department, 1,500 person years of exposure of intimate household or family contacts, or an average of thirty person years of exposure per case of tuberculosis, or six persons exposed for as long as five years each, to a patient lacking any semblance of sanitary control at home and living out the years of his disease without any sense of obligation to avoid infecting others.

Until the practicing physician reports all cases of tuberculosis whether open or closed, positive or negative sputum, to the Division of Health at once on making provisional or suspected diagnosis we shall not be in a position to give the community, the family, the fellow workmen, a protection they are entitled to.

This city has an enviable record of progress in abatement of tuberculosis revealed in an almost uninterrupted fall in the resident death rate from this dease from 222.5 per 100,000 of population in 1889 to 30.4 in the year 1944. Mathematical calculations suggest that, in a disease spread by a chronic carrier and from no other source, the final stages of reduction to entire disappearance should be at a more rapid rate than when the disease is widely prevalent. Chadwick and Pope suggest a probable death rate from tuberculosis in 1980 of ten and a possible disappearance from the list of causes of death by the end of this century. The right answer is anybody's guess, but of one thing we can be certain — any slowing in the rate of regression in the next few decades will be due to professional and civic indifference and not to any lack of the basic facts or of wise guidance as to policies, methods and tests of performance.

The physician in private practice is not only the trustee of the science of human biology, and the sole representative of society licensed to deal responsibly before the law with life and death, but he is the medical conscience of the community. Upon his precise, prompt, wholehearted co-operation, the entire structure of modern public health depends. If in a mistaken spirit of economic self-protection or in the expectation of financial betterment he opposes publicly adopted policies of disease prevention and control within the framework of sanitary law, he destroys in large measure his own professional prestige and draws down upon himself the threat of that most undesirable proposal of social utopians, a compulsory and state-supported practice of medicine, than which I can conceive no worse blow to medical and social progress in our nation.

It has come to my attention here as in other cities where I have made studies of public health services that some physicians and even specialists in tuberculosis consider that apparently healed so-called reinfection type tuberculosis is of no concern to public authority and they accept no obligation to report such patients. This is a mischievous and obstructive practice as it prevents both epidemiological and administrative services indispensable to the proper functioning of a registry and control system.

I find to my surprise a sharp distinction between the attitude of the medical profession here and that in my home town. Any person in New York, regardless of economic status, is welcomed at a tuberculosis diagnostic clinic of the Departments of Hospitals and Health. If the patient has or can obviously afford the services of a private physician, or has been referred for diagnostic consultation to the tuberculosis clinic by his own physician, the record and diagnostic opinion is reported to the family physician. The accuracy, competence, economy of the standard x-ray and personal diagnostic service for the control of this communicable disease are of such a kind as to contribute to, not defract from, the services of the private practitioner.

No private sources could have offered the 500,000 x-rays of the chest as part of the continuing screening process of recent years in New York City. The radiologist and the internist and the tuberculosis specialist have gained, not lost, by the widespread concern with unsuspected pulmonary disease revealed by x-rays of presumably healthy persons.

From a beginning in 1900 when practically all the patients coming to the first tuberculosis clinics were cases of advanced disease there has been an increasing proportion of all clinic patients found to have no tuberculous disease until now almost

80 per cent of the clinic clientele is found to be non-tuberculous.

Certainly it is contrary to good public policy, against the interest of patients and of the local medical profession that a tax-supported diagnostic service for tuberculosis should be denied to any person, employer or employe, mistress or maid, rich or poor, for the reason that many such persons could afford the consultation and x-ray fee of the private practitioner. People should be encouraged to come to such free tuberculosis diagnostic clinics, and their physician of choice or preference should receive the report of the clinics' findings.

The free chest x-ray to establish or exclude the diagnosis of pulmonary tuberculosis appears to me to be as much a right of the citizen as it is a duty of civil government to offer, and entirely comparable to, the blood serology offered by the diagnostic laboratory of the state or local department of health to identify cases of syphilis.

If under such ideal conditions of organization as have already been proved practicable, a miniature x-ray of the chest and a blood test for syphilis can be provided by public authority for little more than twenty-five cents per person, obstruction against the widespread, not to say universal, use of such tests by the public would bring nothing but discredit upon the medical profession.

Among the factors leading to delay in reporting of cases of tuberculosis by the private practitioner is the inclination of some physicians to spare the feelings of patient and family by not declaring the actual diagnosis and then by attempting to continue a regime of care of the patient at home as long as the family can continue to pay for his services. I am not at the moment concerned with the ethical weakness of the physician's position in such cases, but solely with the effect upon the origin and spread of the infection in the community.

Home care of the tuberculous is of course possible but except under relatively rare conditions whether for the well to do or for the wage earner, it is a distinctly second-best choice from the point of view of therapy and permits almost inevitable transmission of infection to household contacts.

When we recall the high probability of infection of nurses under even rigid hospital discipline and with excellent equipment and management in sanatoria, we cannot doubt the higher probability of such infection in home care of the tuberculous.

An instance of misfortune due to failure of a plant physician to report a case of tuberculosis in a young woman applicant for employment came to my attention as illustrative of indifference on the part of an occasional physician to his obligation under the law. The pre-employment applicant had a child of tender age. The mother felt well, ignored the doctor's diagnosis, sought and obtained employment elsewhere, and within a year was diagnosed as advanced tuberculosis and the sanitarium prognosis is grave. What the plant physician did not realize and probably is not yet aware of is that the result of the report he should have sent would have been medical and nursing follow up and offer of assistance by the Department of Health, persuasive education in the interest of patient and child, a probable early admission to hospital care, avoidance of infection of the child and a rehabilitated life of self-support.

It is well from time to time to remind ourselves that the reassuring progress in control of tuberculosis has been in spite of all the incompletenesses of reporting, in spite of delayed reporting, in spite of the insidious and silent nature of early pulmonary disease and in spite of the entire lack of any specific resources for creating immunity or for cure in the chemotherapeutic sense.

We know so much we do not use that there is no excuse for discouragement or delay. The question is one of relative speeds of progress, always the hope that within our lifetime, our offspring will escape wholly what we know has decimated our predecessors and cruelly handicapped our contemporaries. When my grandparents made their home in New York City in 1838 the death rate in that city from tuberculosis was not less than 300. When my parents started their family in 1868 the rate was 250 or over. In the years when our children were being born in the first decade of this century the rate was about 150. Our grandchildren are living in the same city where a rate of 45 is current today. In each generation but the latest, the disease has exacted its toll of disability or death.

May I suggest that with economy and efficiency we can guarantee freedom of the succeeding generations from tuberculosis if we undertake the following programs—one of discovery

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THE PROBLEM OF MEDICINE IN RURAL HEALTH

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I UNDERSTAND that your Program Committee chose me to discuss the problem of medicine in rural health in this symposium because I am a member of the Committee on Rural Medical Service of the American Medical Association. Since I have been a member of this committee only a few weeks and the committee has not issued a report of its findings, the material in this paper is not to be construed as that of the committee.

Rural health has been a problem ever since this country was founded. An increasing interest in rural health has developed, especially during the past fifteen years. The Farm Foundation, Farmers Union, Farm Bureau Federation, Grange, and the Federal Security Administration, have departments or committees devoted to a study of the problem. The Farm Foundation sponsored a conference on medical care and health services for rural people in April, 1944. Representatives of the above-mentioned farm organizations, government agencies, state agricultural colleges, farm publications, medical, dental, and hospital associations, United States Public Heatlh Service, Children's Bureau, United States Senate Committee on Education and Labor, American Legion, National Congress of Parents and Teachers, et cetera, attended the conference. According to the printed report of this conference[1], availability and cost are the two outstanding problems in rural medical care.

We are all aware of the fact that physicians have gradually moved from the strictly rural areas to the larger urban centers during the past twenty-five years. There are statistics available which show that many physicians have moved from the rural states to industrial states. This is especially true in the Southern states and also, to some extent, in the Great Plains states during the drouth years. The war served to increase the shortage in these areas because many physicians chose to enter military service rather than stay in the states with low per-capital incomes. The reasons for this migration are obvious. Inadequate remuneration, the necessity for traveling long distances to reach the patient, lack of hospital and adequate diagnostic facilities, absence of consultation service, long hours of work, inadequate facilities for education of their families and for recreation, and difficulty in arranging for vacations or postgraduate study, have driven too high a percentage of rural physicians into the larger centers. The solution of this problem is extremely difficult. The complaint of non-availability of physicians comes mainly from the sparsely populated areas, particularly the Dakotas, Nebraska, Montana, Wyoming, Nevada, Arizona, New Mexico and Idaho. In these states the population is not only small, but the distance between trading areas and centers are great, roads—except the main highways—are poor, and there are deficiencies in the usual facilities for transportation. It would seem that there is small chance of changing all of these basic factors in this particular area. The problem is to bring the doctor to these people, or to make it possible for the people to get to the doctor.

Much has been written concerning the reasons for the failure of young doctors to locate in rural areas. The most common reason given is that the average small town does not have hospital facilities. A great wave of enthusiasm is spreading throughout the rural sections of this country for the construction of small rural hospitals. However, it will be extremely difficult to bring this about because of the initial cost of construction and equipment, the cost of maintenance, the difficulty in maintaining adequate medical and nursing personnel, and, most important of all, the tendency of rural people to by-pass the local physician and small hospital to consult a physician, and possibly enter a hospital, in the larger center, regardless of the distance. It is true that there are notable exceptions to this rule, for all of us know of practitioners in small towns who have retained the complete confidence of their people and have successfully operated small hospitals in sparsely settled localities. After a rather careful study of the problem in my home states, in which the above-mentioned factors are very apparent, I am convinced that it is unwise for the average small community, even though it be a county seat, to

Read at the North Central Conference, Saint Paul, Minnesota, November 11, 1945.

construct a small hospital with about 25 or 30 beds. Several such hospitals were constructed in North Dakota through government grants during the drouth period, but none of them was a success. They failed because it was impossible to hold a successful physician who could do all the things demanded of him, particularly in surgery, even though hospital beds were available. The same fate lies in store for those small communities who attempt to build small hospitals unless the hospital is subsidized in one way or another, facilities for laboratory and x-ray diagnosis are provided, and consultation is readily available. I believe it is much more sensible to encourage the development of small community health and diagnostic centers, strategically located in the smaller towns. Young physicians can undoubtedly be influenced to locate in small towns, provided office facilities, living quarters, and a few hospital beds for obstetrical patients and emergency cases are available. The ambitious young physician, particularly the one who wishes to specialize, will not stay, but his experience will be invaluable, he will probably be able to save a little money, he will be performing a real service to the surrounding rural population, and when he leaves, another young physician can be found to replace him.

The relative cost of a service, or commodity, depends on the income of the consumer and his evaluation of the worth of the service or commodity. The cost of medical care is a problem of great concern to rural people, according to their spokesmen. Of necessity, the cost of rural medical care is relatively high, if the physician is obliged to travel miles to reach the patient. The fees for the actual services rendered by the rural practitioner are not exhorbitant; they are usually much lower than the fees charged for comparable services in urban areas. Improvements in transportation, particularly in the development of good highways which are passable throughout the year, will accelerate the growing tendency of rural people to bring the patient to the doctor. This will reduce the cost of medical care; it will conserve the time of the physician, who, too often, spends the majority of his working hours in traveling to and from his patient.

The most serious difficulty facing the farmer, however, is the variability of his income. This is particularly true in those areas in which there is a sparse population, and in which the factors which tend to increase the cost of medical care because of the distances to the physician and hospital, are present. I believe most students of rural economics will agree that if the income level of farm families could be elevated, at least to the point where it has been during the past five years, there would be very little concern over the cost of rural medical care. Miss Elin Anderson, in summarizing the Farm Foundation Conference held in the spring of 1944, said: "The crux of the problem, as we know, is economic."[2] Dr. R. C. Williams, of the United States Public Health Service, who was chief medical officer of the Farm Security Administration during the drouth years, said, at the same conference: "Perhaps all I have done has been to rear the ugly heads of some impossible questions, but I do think the whole thing comes right back to that; all our discussion, must, although it may wander and veer around, come automatically back to that crux of the situation—in short, to money."[3]

The only solution of the problem of cost of rural medical care is to raise the level of the farmer's income, or, reduce the cost of the physician's services, or, spread the cost of medical care through a prepayment medical insurance plan. The farmer must raise his own income, with the help of Government subsidy, if necessary. A reduction in the rural practitioner's fees cannot be made unless the majority of his patients are brought to him. If his income drops he will simply move on. Prepaid medical insurance will solve the problem, provided it can be operated on a sound actuarial basis, and the farmer is able and willing to pay for it. Many spokesmen for the farmer insist that he cannot afford to spend $48.00 or $50.00 per year for catastrophic medical and hospital protection. The reason given is that his total cash income will not warrant such an expenditure. A government agency has estimated that in 1944, 40 per cent of the farmers had an annual income of $700.00 or less. This is an impressive figure, but does it mean that 40 per cent of the farmers had a *cash net income* of less than $700.00 after the cost of rent and food had been deducted? There are millions of families in urban districts who have a net income of less than $700.00 after the cost of rent and food has been deducted. In considering such figures, it should be emphasized that the remaining 60 per cent of the farm population supposedly had a cash net income of over $700.00 per year. Economists, particularly those who are directing their attention

to the cost of rural medical care, might well ask the farmer what he spends his cash income for. Is it not possible that many of them squander $48.00 or $50.00 per year on trivialities, which could well be used for their health protection. This, of course, involves the question of evaluating the things in life. No nation in the world spends as much money for tobacco, cosmetics, candy, movies, etc., as we do in the United States, and this tendency is as prevalent in rural areas as it is in urban areas. Health education will impress all of our people with the value of good health, and the need for budgeting the family income to pay for the illness that will certainly come, whether that payment be on a fee-for-service basis, or it be covered by an insurance plan.

The following four-point program is offered for the solution of the rural medical and health problem:

1. The number one objective in the constructive 14-point program of the American Medical Association for the extension of improved health and medical care to all people is as follows: "Sustained production leading to better living conditions, with improved housing, nutrition, and sanitation, which are fundamental to good health; we support progressive action toward achieving these objectives." A sound agriculture in which the uncertainties of annual income will be reduced to a minimum through irrigation, where necessary, utilization of modern methods and machinery, and the education of the future farmer in our high schools and agricultural colleges will reduce the number of farmers who find it difficult to pay for medical care or health protection.

2. The development of prepaid medical insurance plans which will succeed in the rural areas. Unfortunately, there is not sufficient actuarial data available at present on which such plans can be developed. As physicians, we must assume the responsibility for the development of plans which have some hope for success. In doing so, we should realize that there may be losses, especially at first, but those of us who render the services must be willing and able to absorb the losses. Almost all physicians, and most of the farm organizations in this country, are opposed to a system of federally controlled, compulsory, medical insurance. It would seem wise to explore the possibility of government subsidy of local prepaid medical insurance and hospital plans in those states where definite need is demonstrated, provided, however, that the plans are administered by the proper local agency in the states involved, with the help and advice of the medical profession. This suggestion may be violently opposed by some, but we must remember that the majority of the complaints being offered that medical care is inadequate and costs too much, come from those areas which, because of local economic conditions, may not be entirely able to correct the situation themselves. Federal aid to such areas, under a system in which the funds are controlled locally, will not jeopardize the American system of free enterprise.

3. Expansion of public health facilities. We all know that public health facilities have not been extended to the rural communities as rapidly as they should have been. The reasons are the same as for the fundamental problems discussed above. Trained public health personnel has not been available and rural people have been unwilling to levy sufficient taxes to carry on a successful public health program. In late years, funds have become available through social security funds for the development of more and more public health units. The state health department controls the funds allocated to the unit, usually chooses the personnel, and determines the policies. I believe that we, as a profession, should support a program in which a well-organized public health unit will be developed in every rural community which has a population large enough to support it. Preventive medicine is extremely important, and has not been given its proper emphasis in rural areas. The development of rural public health units will offer an inducement for young physicians to locate in rural areas because they can be placed on a definite income for the public health work they do in the community. In addition, if some of the plans now being made by the Federal Government materialize, office and hospital facilities and living quarters will be provided in the community health center. We must insist, however, if we are to support this program of expanding public health facilities, that preventive and curative medicine be clearly defined. With the control of this program resting in the state or local subdivision, it should be possible to develop a common understanding so that the public health department will not take over the practice of medicine. One of the most important functions of such a health unit will be that of health education, which has been woefully

weak in the past, especially among rural people. When the people know how to prevent disease, and what to do when they are confronted with an illness, they will have a better appreciation of the value of good medical service and will be more willing to pay for it.

4. Continued study of the problem of rural medical care. Each State Medical Association should have a committee to study the problem. The medical profession should co-operate with every agency or organization in the state which is interested in the welfare of the people. We must not only support, but also provide the leadership in, the state health planning committees, whose membership should represent all organizations and interests in the state. Through such contacts we will soon find that the people are keenly interested in the problem of medical care. Laymen may not understand all phases of the problem; they may have some wrong ideas of what can be done, but experience shows that through conferences around the table, a common viewpoint can usually be reached.

References

1. Medical Care and Health Services for Rural People—Report of conference held at Chicago, Illinois, April 11-13, 1944. Published by Farm Foundation, 600 South Michigan Avenue, Chicago 5, Illinois.
2. Ibid: Page 62.
3. Ibid: Page 147.

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of pulmonary tuberculous disease and the other of isolation or adequate sanitary supervision of persons discharging the tubercle bacillus from the nose and mouth. We shall achieve the first objective most quickly and at least cost if we concentrate upon x-ray surveys at public expense of the following five categories of persons:

1. Those with suspicious pulmonary symptoms
2. Contacts with known cases of tuberculosis
3. All general hospital admissions
4. Racial and economic groups showing abnormally high incidence
5. Workers in trades exposed to silica dusts.

To achieve our second goal we must have both popular and unanimous professional support for every detail of diagnosis, reporting and sanitary control of infected persons.

The Sanitary Code of the City of New York like those of most other cities of our country includes ordinances requiring:

1. Reporting of all forms of tuberculosis, by physicians and by persons in charge of hospitals, institutions and dispensaries, giving full name, address and age of the patient, within twenty-four hours of the time when the case is diagnosed. (All such records are to be confidential)
2. Isolation of patients capable of spreading the disease, a duty of the physician, if the patient is in a communicable stage.
3. Exclusion of children with communicable tuberculosis from day-care institutions
4. Exclusion of teachers, custodians, principals, etc., with tuberculosis from public, private or parochial schools
5. Forbidding of spitting in public places
6. Pasteurization of milk
7. Segregation of non-coöperative or recalcitrant spreaders of tubercle bacilli by use of the authority of the courts if necessary.

In closing, let me say that what the public health expects of the private physician is no more and no less than it requires of every other citizen, i.e., prompt compliance with the law. Way over and beyond this, popular opinion and medical tradition look to the medical profession with confidence that each increase in knowledge will be made available, appropriately under the conditions of private practice, and so far as need and economy are dictated by civil government, to give accurate diagnosis, humane treatment to the sick and prevent the spread of communicable disease from the sick to the well.

The medical profession has exercised the disciplines of education and of ethics among its members. Any failures of standards within these fields will be best corrected by giving the facts to the organized local and state medical societies.

King Edward VII of England, when told that tuberculosis is a preventable disease, asked why it has not been prevented. It can be prevented in our time if we use our present resources.

RELOCATION OF PHYSICIANS IN IOWA

JOHN C. PARSONS, M.D.
Secretary, Iowa State Medical Association

Des Moines, Iowa

OUR work on the relocation of physicians in Iowa started about a year ago when the Bureau of Information in Chicago, at the AMA headquarters, sent us a form to be filled in for each county in Iowa. You are all familiar with those forms, I am sure. One side is devoted to information about the health facilities of the county—the hospitals, public health and other medical facilities, number of physicians in each age group. The other side of the form is given over to information about the county itself—its character, location and climate, population, principal cities, schools, retail sales, telephones, miles of highway and dwelling units. The first form also asked for information about the churches in the county.

The American Medical Association provided some of the information from its office, and asked us to obtain the rest. We sent the forms to our county society secretaries and asked them to fill in as much as they could. What they did not provide, we dug up as best we could. Many of them—in fact, most of them—did not list the doctors by age groups, and we had to do this for practically the entire state.

This work was completed in the spring, but we felt it did not give us a complete picture, and so the first of May we wrote every county, stating that a few doctors were asking about locations because of release from service, or because they were physically unfit for service. We asked the counties to let us know if they needed additional doctors, and what towns needed them. We also said, "If you are holding the locations for your own doctors who are in service, and don't want anyone, tell us that also."

We got a pretty good response on that, although the towns which were listed as needing physicians were small ones, 500 to 1,000 population for the most part. Also many counties said they did not want new physicians, but were holding locations for their own doctors in service.

The next step we took may not meet with unqualified approval, but it did give us some clues. We talked to detail men covering the state, asking them where doctors were needed. Usually they could give us the names of a number of towns that really needed doctors.

Next, we began to get requests from doctors who were getting out of service asking about locations. We wrote them very fully of the towns we had listed, giving all of the information we had about them, and giving them the name of the doctor whom they should talk to in each county.

Now many of the doctors are coming into the office to talk over the matter of getting established. Each one is an individual problem, and our method is probably never twice the same in talking to them. We find out whether they have practiced before, whether they wish to start out on their own, whether they want an assistantship to start with, or what specialty they may have. If they have a preference for a certain section of the state, we go over the towns in that locality. We tell them what we know about the county medical society, whether it is active, what the hospital facilities are or what the prospects are for new hospitals. We give them the names of doctors to talk to, and advise them to talk to as many doctors as they can. In fact, we give them as complete a picture as we have.

Some of these doctors have visited various towns in the state, talking to doctors in each place, and they have come back to report that there is a great need for doctors everywhere—that they can settle any place and make a go of it. Persons of their temperament will probably succeed anywhere, too.

Some of them are uncertain, however, particularly when starting out on their own for the first time, and they need encouragement. They are afraid it's going to be a lot tougher than it really will be. These are the ones who are encouraged to locate where there is a stated need for a doctor and where the county medical society will co-operate from the start.

Iowa has many religious communities, and it

(Continued on Page 45)

Presented at the North Central Medical Conference, St. Paul, Minnesota, November 11, 1945.

LUMBAR SYMPATHETIC BLOCK AND THAT POSTPHLEBITIC LEG

H. O. McPHEETERS, M.D. and H. A. ALEXANDER, M.D.
Minneapolis, Minnesota

THE word "phlebitis" means an inflammation of the vein. This should always be regarded as of serious import. Even though the great majority of attacks of it are of little consequence and clear up spontaneously, we never know just what will happen in an individual case. Phlebitis is one of the most common complications of all types of surgery. It has perhaps most often been seen in the postpartum case, although the surgeon must expect and fear its onset in every case. Most often it involves the deep veins in the lower leg and it is this particular involvement that I wish to discuss here.

The usual history of the onset of a phlebitis is one of surprise. A patient who has made a perfectly normal postpartum or postoperative progress may begin to run a fever of 99 to 100 degrees with no symptoms indicating the cause. Another patient may have a slight pain and tenderness through the calf noticed during the bath, while another patient may have a violent onset with a chill, fever and severe pain through the entire lower leg, followed by extreme swelling of the part even to the crest of the ilium. It is oftentimes difficult to recognize and may only be surmised from the unexplained fever. The Homans signs, with pain in the calf when the muscles are put on tension and tenderness on deep pressure through the calf, are usually positive. The violent case with a typical onset and the secondary findings cannot be missed.

Pathology.—The primary pathology here is one of damage of some type to the intima of the vein wall. This may be due to trauma, infection, or chemicals. This in the presence of a slowed blood stream as we have when a patient is quiet in bed after delivery or after an operation, or with an altered state of the blood constituents, is all that is needed to start the deposit of the blood platelets and the formation of a thrombus. If the process is mild and the injury is very slight, we may have the condition commonly spoken of a phlebothrombosis. In this case the vein is simply filled with a thrombus which is but little more than a simple red thrombus or blood clot similar to the postmortem clot. It is not fixed to the wall of the vein firmly, but on the contrary lies there filling the vein and ready to float onward and upward with the blood stream with the first sudden stimulation of the venous current, as with massage or with active muscular action. This is the thrombus to be most feared. It often produces no symptoms and is the most common source of an embolus. But it is not with this silent phlebothrombosis that we are most concerned in this presentation. It is rather with the severe deep thrombophlebitis with the thrombus firmly fixed to the wall of the vein and which causes the train of symptoms and complications that may last for life that we are particularly interested in at this time.

By their experimental work, Ochsner and DeBakey have shown that the onset of a severe thrombophlebitis causes an overstimulation of the sympathetic ganglia along the lumbar spine with a secondary and resultant spasmodic contraction of the arterioles throughout the extremity. This in turn causes a stasis of the circulation, stagnation of the lymphatic circulation and venous congestion. The leg becomes swollen, mottled and at times almost white. At other times it is cyanotic. This depends on the difference in the degree of the lymphatic or venous stasis predominating. The condition is usually painful and the entire leg is sore and tender. At times the patient complains of even slight jarring of the extremity.

Prognosis.—If no active treatment is given the course of events usually becomes no less than tragic. Too often the doctor has merely commented, "This is just too bad, but we will have to make the best of it." He would tell the patient, "You have a serious complication and will have to rest in bed until nature has repaired the damage." This would often mean weeks and months of bed rest and invalidism, with the ever-present chronically swollen extremity and the cold, clammy, cyanotic lower leg and foot. The later complications of pruritis, eczemas, varicose veins, ulcerations, dermatitis and fungus infections about the lower leg and foot effectively cripple the patient both mentally and physically, and it is these conditions that I wish to discuss.

Presented before the Minneapolis Surgical Society, October 4, 1945.

All the above complications develop on a "stasis basis." Therefore, it is logical that we should approach their treatment in just the reverse order. Rather than treat the skin condition present first, let us attempt to correct the circulation and get more fresh arterial blood to the part with food for the tissues, and get rid of the edema, congestion and stasis with their associated accumulation of plasma proteins and products of tissue damage. It is these that cause the permanent fibrosis in the fascia, which when well developed remains there for life.

If Ochsner and DeBakey were right in their conclusion as to the overstimulation of the sympathetic ganglia as the cause of arteriole spasm, then they were right also with their theory of correcting the spasm by the injection of novocaine to put them out of function. This they did with their "lumbar sympathetic block." They found that by injecting 10 c.c. of one per cent novocaine solution along the area of each of the upper lumbar ganglia, the spasm of the arterioles was relieved and the arteries would again open widely and even more than the normal amount of fresh blood would flow to the part. This would wash on through the tissues and tend to clear them of the stagnation products. In this way, the circulation would gradually return to normal with a healing of the eczemas, ulcerations and fungus infections that had resisted all previous efforts. In many cases the normal state of vitality can never be regained and the complications will tend to recur, but it is the healing of the condition present that we are hoping for and we can then try to prevent a future recurrence. All the usual, accepted treatments for these complications should be used at the same time. The lumbar sympathetic block is merely an additional trump card in our pack of tricks to cure some of the most distressing and annoying end results of an old thrombophlebitis of years before. If the block is used at the onset of the phlebitis, all this chain of events can be prevented and the patient's leg returned to normal, in the great majority of cases in the course of a few days' time.

Case 1.—Mrs. H. B., housewife, thirty-six years old, was seen in May, 1936, with a history of having had a "broken vein" after confinement fifteen years previously, when she had been in bed for several weeks. Both lower legs have swelled much ever since. Examination showed the patient with both lower legs badly swollen, edema grade two, the right worse than the left, and a few scattered veins, size two, over the lower leg. The patient was seen again in May, 1936, with an acute eczema over the right lower leg and foot. Much edema was still present. In June, 1940, the patient was again seen, with extensive eczema about the lower leg and foot, with a severe fungus infection and typical fungus odor. Edema was present in spite of a supportive bandage. The patient was sent to the hospital in August, 1942, for the same condition. In December, 1943, the patient had a repetition of the skin condition with poor response to treatment. At this time I did a lumbar sympathetic block with a very fine immediate response and rapid healing of the skin and dermatitis. When seen in June, 1945, the patient had been well, had used a supportive bandage during the past year, but now has edema grade two without the bandage. The dermatitis had remained controlled.

Case 2.—J. P., a laborer, aged thirty-four, was seen in May, 1942, with a history of a bad thrombophlebitis in the left leg, following a pneumonia in 1933. He had been in bed for three months. The lower leg had been swelled ever since. Ulcers had first appeared in 1937. An open ulcer was now present over the external surface of the lower third of the leg which had been open for the past seven months. There was an extensive eczema and dermatitis over the left lower leg. The patient received some help from a varicose vein ligation and supportive bandage. In 1943 the condition was worse than ever. The feet were cold and clammy and there was a typical severe fungus infection about the ankle and foot. He received much help from a lumbar block, and the skin cleared up more rapidly than before. In April, 1943, Dr. S. Maxeiner and I did a lumbar sympathectomy, removing the upper four lumbar sympathetic ganglia on the left side. There was a marked improvement in the condition immediately. The skin became dry and warm, the eczema cleared entirely, and the edema practically disappeared. In September, 1945, the patient had two slight recurrences of the ulceration on the lower leg following trauma but each of these healed well with support. The patient now has little or no edema when wearing the supportive bandage.

Case 3.—J. E. S., a grocer, aged forty-five, was seen in July, 1944, with the history of having had varicose veins since the first world war. He had had ulcers on the inner and external surfaces of both ankles for the past six years. When seen at that time he had an ulcerating eczema with a fungus infection about both ankles and feet giving a typical fungus odor. The feet were cold and clammy and there were extensive varicose veins of both legs, involving both the short saphenous groups and the left great saphenous group. There was edema, grade two, of both lower legs and feet. I did a ligation of the left great saphenous and both short saphenous veins, with much relief. The patient continued to have recurrent attacks of the dermatitis about both the ankles, not severe, however. When seen in April, 1945, the edema was still grade one, with dermatitis and superficial ulcerations about both ankles, even if the patient wore a tight supportive bandage. I did a lumbar

sympathetic block on the left side and later on the right side. This was repeated ten days later. When seen in September, 1945, the edema was almost gone and the patient wore bandages only half of the day. The skin condition was entirely healed and the skin was dry and warm. I advised him that if he should have any recurrence, he should have a lumbar sympathectomy.

Case 4.—A. P., a mechanic, fifty-seven years old, was seen in December, 1942. He gave a history of trouble in the right leg for thirty-three years, beginning with a bruise, and followed by milk leg which had been present ever since. The patient had had recurrent attacks for the past fifteen years and the leg had been swollen continuously for the past five years and is now very painful. Examination showed the right lower thigh about four inches larger than the left and the right lower leg at the mid-third three and one half inches larger than the left. There was a very extensive necrotic ulceration over almost all of the lower half of the left lower leg anteriorly and a weeping eczema about the ankle which was very painful. The great saphenous vein was size three in the groin and size two in the thigh and there was much cellulitis of the tissues of the lower leg. The patient was put in the hospital and hot packs were applied. Later 200 Braun seed grafts were implanted into the ulcer area and later a saphenofemoral ligation was done. In February, 1944, I did a lumbar sympathetic block. Today the patient has but little edema which is well controlled with the bandage. The ulcers are healed, and the skin is dry and warm. The patient will always have to wear some type of support part of the time.

In conclusion, I would emphasize that the lumbar sympathetic block is of much more value and importance in the treatment of thrombo-phlebitis than has been commonly recognized by the profession. The results following its use in the acute case are often miraculous. We now find that the chronic case with semi-invalidism of years' duration due to the edema of the lower leg with the complicating dermatitis, stasis eczemas, and ulcerations can be helped a great deal by its use. It should be employed in every such case.

RELOCATION OF PHYSICIANS IN IOWA

(Continued from Page 42)

is wise to bear that fact in mind when advising a young doctor. If he is a Lutheran, he may be happier in a location in which the majority of the people are Lutherans. We had an instance this week in which a young man was definitely attracted to a certain opening, but it was a Catholic community and he was not a Catholic. He finally decided against it, and this was probably a wise decision.

In the final analysis, the doctor himself is the only one who can decide where he will locate. Probably the best service we can offer is talking to him. When we sit down and tell him all we know about each opening, bringing out the special features of each one, its background, the little personal things we may know about, then we have given him a yardstick by which he may measure it. We also feel it is important to direct him to a physician we think will take time to talk to him and go over the situation with him."

After we give him all of this information and background, he may go out, look over the place, and not like it at all. He may find an opening we didn't know existed, and we feel pretty futile. We really feel we have little concrete to offer. We have a list of about twenty towns, all but three or four under 1,000 in population.

The best we can do is give each man our personal attention, encourage him, and give him as complete a picture as we can. Possibly the many little things we mention help him set up certain criteria in his own mind which he may utilize in coming to a decision. Some of the younger men have no yardstick by which to measure a location, and maybe we help them attain it.

We're glad they are demobilized, and we hope they find a good location in Iowa. If we can get across to them the fact that they are wanted and that there is a place for them, maybe we are of some help.

MEDICAL EXPERIENCES AT DACHAU

MAJOR JACK A. KILLINS, MC, AUS
and
CAPTAIN JOSEPH L. POSCH, MC, AUS

THE German concentration camp operated by the SS troops at Dachau has received widespread publicity. Because of this general interest we have considered it worth while to record our medical observations made between May 3 and June 12, 1945, while we worked at Dachau with the 127th Evacuation Hospital. We have adhered closely to an objective recording of our own experience. The horrors of the camp with their social and political implications have been left to other better qualified writers. In limiting our discussion to the cases we have personally examined and cared for, we have made certain deficiencies inevitable. We were originally assigned as a surgical team. However, the influx of patients and the preponderance of medical cases soon required that we assume care of approximately half the patients with pulmonary tuberculosis as they were diagnosed and segregated. All known cases of typhus in males were sent to the 116th Evacuation Hospital where the care of selected cases was supervised by members of the U. S. Typhus Commission. Consequently, the amount of tuberculosis reported by us is disproportionately high, while the amount of typhus in the camp is in no way indicated by the few cases we saw and diagnosed after they had been admitted to our wards. Our surgical cases are fairly representative of the entire camp.

We examined and cared for 308 patients of the 2,268 admitted to the 127th Evacuation Hospital during its stay in Dachau. All patients were white; there were 10 females and 298 males. The nationalities represented and the number from each nation are indicated in the following list:

Polish	93	Rumanian	8
Russian	57	Dutch	6
Hungarian	30	Lithuanian	5
Italian	24	Austrian	3
Yugoslav	20	Spanish	2
Czechoslovakian	18	Greek	2
French	15	Estonian	1
German	11	Latvian	1
Belgian	8	Nationality unknown	2

The average age was 31.7 years. Our youngest patient was thirteen and the oldest was sixty-seven. Forty-seven of our patients were twenty or less, twenty-four were fifty or more.

In almost every case the patients were extremely thin and weak. They were tired, listless and disinterested in either their surroundings or in their recent liberation. As they were admitted, patients were bathed in soap and water and 2 per cent cresol solution, their scalps shaved, their bodies dusted with DDT powder, and they were taken through the x-ray department for radiographs of their chest. Many arrived on the wards completely exhausted. Their average weight on admission was 117 pounds; the lowest weight recorded for an adult was 86 pounds. A very few who had been imprisoned but a short time or who, because of their technical skills, had received extra rations, had weights approximating normal.

Ninety-nine patients suffered from one or more infections in the skin or subcutaneous tissues. These included acute abscesses, old incised or spontaneously draining infections which left indolent ulcers of months' duration, and deep-seated, poorly defined areas of inflammation in the subcutaneous tissues. Decubitus ulcers were common. The combination of extreme emaciation, weakness and unpadded wooden slabs for beds was so conducive to their development that it is only remarkable that there were not more such cases.

Twenty-seven wounds of external violence, including three compound and two simple fractures, occurred during the two weeks preceding our arrival at the camp. These patients were cared for initially at the prison camp hospital whose facilities were hopelessly inadequate. All the wounds were frankly suppurative when we saw them. Older wounds and injuries accounted for seven other cases. There were seven patients with osteomyelitis originally caused by some injury inflicted by the German SS troops or by an injury accidentally incurred in the prison compound.

Ten men had gangrene. In at least three cases the history clearly indicated the gangrene was a

Major Killins has been relieved from active duty and has resumed his fellowship in surgery at the Mayo clinic, Rochester, Minnesota. Captain Posch formerly lived in Saint Paul, Minnesota.

complication of typhus fever. Two of these men had bilateral symmetrical gangrene of the feet. The third had a sharply defined gangrenous area in the left cheek extending completely through the buccal tissues into the mouth.

There were five amputations of the lower extremities which had been performed in the prison hospital. All were of the guillotine type. These patients were in relatively good general condition and their amputation stumps covered with granulations.

Nineteen patients suffered from scabies. Many of the scabetic burrows were secondarily infected. In all cases the scabetic infection was incidental to some other condition requiring hospitalization.

Eleven high fevers with headache and mental confusion among our patients were diagnosed as epidemic louse-borne typhus and transferred to the hospital designated for such cases. The diagnosis was subsequently confirmed by the appearance of a typical rash and the appearance of proteus agglutinins in the circulating blood.

Enteritis with diarrhea appeared in forty cases. The patients themselves ascribed this to the increased food intake since their liberation. The recent onset and the infrequency of pathogens in the stool cultures tends to confirm the observation of the patients. In one case, Shigella paradysenterii Type IV was cultured from the stool, and in another, Shigella ambigua was found. Following a paroxysm of coughing, one patient found an adult Ascaris lumbricoides in his sputum cup.

There were two cases of parotitis, both of which responded to penicillin and hot packs. Neither required surgical drainage.

Seven cases of bronchial pneumonia developed while under our care. None of these patients died.

We saw 115 patients in which the roentgenologist had made an unequivocal diagnosis of pulmonary tuberculosis. Seven more were observed in which the roentgenologist reported bronchopneumonic infiltration, suggestive but not typical of tuberculosis.

Acid-fast bacilli morphologically typical of mycobacterium tuberculosis were found in the sputum of thirty-nine patients. Since the laboratory facilities were strained, not all patients had sputum examinations and it was impossible to repeat the examination more than three times on any patient.

Forty-two patients with pulmonary tuberculosis had some additional unrelated condition such as a cutaneous ulcer, gangrene of an extremity or a wound of external violence.

Four tuberculous patients had draining sinuses in an extremity with marked lime salt absorption of the osseous structure distal to the sinus and a presumptive x-ray diagnosis of tuberculous osteomyelitis.

One of these patients, a nineteen-year-old Belgian with bilateral pulmonary tuberculosis and an x-ray diagnosis of tuberculous osteomyelitis of the left metatarsals, became irritable, apprehensive, frightened and hypertonic. His neck became rigid and bilateral ankle clonus was present. Spinal fluid examination revealed chlorides 595.7 mg. per cent, protein 135 mg. per cent, 95 white blood cells per cu. mm. (100 per cent lymphocytes), sugar 54.1 mg. per cent, colloidal gold 5555555531, Wassermann negative. Culture for routine organisms was negative. Examination of the centrifuged sediment was negative for acid-fast bacilli. A guinea pig was inoculated with the spinal fluid after three days of treatment but this report is not available. Treatment with fourteen daily intrathecal injections of 20,000 Oxford units of penicillin in 10 c.c. of physiological saline plus 20,000 Oxford units of penicillin intramuscularly every three hours was followed by a remission of all central nervous system symptoms and a return of the spinal fluid to normal.

The average hemoglobin recorded was 66 per cent (Tahlquist), a higher figure than we anticipated, considering the general debility of our patients.

The white blood counts recorded were not remarkable. The proportion of patients with more than 10,000 leukocytes per cu. mm. correspond closely to the proportion of patients with abscesses or other pyogenic infections. Only seven had leukocyte counts of less than 5,000 per cu. mm.

Cultures of the exudate from infected wounds and the material from abscesses revealed the following pathogenic organisms:

Streptococcus pyogenes hemolytic	18
Proteus species	10
Staphylococcus albus nonhemolytic	7
Diptheroids	5
Staphylococcus aureus hemolytic	4
Escherichia coli	3
Salmonella enteritidis	2
Staphylococcus aureus nonhemolytic	1
Aerobacter aerogenes	1
Corynebacterium	1

RECORD OF PATIENTS WHO DIED

Case No.	Age	Nationality	Time in Hospital	Remarks	Autopsy	Laboratory Findings
1	45	Hungarian	12 days	Abscess over rt. scapula I & D 1,000 c.c. pus, severe intractable diarrhea. Died 10 p.o. day. Generalized anasarca, acute embolic and glomerular nephritis. Cirrhosis of liver. Extensive ulceration transverse colon. Pulmonary tuberculosis.	Yes	Hb 56%, WBC 4,100, RBC 2,920,000, Plasma proteins 4.9, Hematocrit 28.5. Urine: alb two plus, pus cells 2 HPF, RBC 25 HPF, granular casts. Wound culture: Salmonella enteritidis. Stool culture: Negative.
2	40	French	12 days	Severe subcutaneous infection lt. lower leg incised prior to admission with necrosis of skin around incisions. Rt. empyema treated by multiple aspirations. Extensive bilateral caseous tuberculosis with cavitation, severe malnutrition.	Yes	Hb 65%, WBC 27,700. Plasma proteins 4.5. Hematocrit 27; Urine neg. Leg wound culture: Proteus spp., Strep nonhemolytic.
3	22	Russian	12 days	Gun shot wound left hand and left thigh. Three massive hemorrhages from lower bowel. Numerous sharply marginated ulcers in colon.	Yes	Hb 68%, WBC 7,150, RBC 3,420,000. Plasma proteins 4.8. Hematocrit 29.2. Bleeding time 2.5 min.; clotting time 4.5 min. Hand wound culture: E coli, Staph albus hemolytic. Strep. viridans.
4	50	Hungarian	18 days	Gun shot wound rt. knee compound comminuted fracture prox. end rt. tibia. Suppuration rt. knee joint and subcutaneous tissues of entire post aspect of rt. leg.	Yes	Hb 55%, WBC 5,800. Wound culture: proteus spp.
5	20	Yugoslav	19 days	Bilateral severe pulmonary tuberculosis. Left tuberculous empyema. Tuberculosis of liver and spleen. Severe malnutrition.	Yes	Urine neg. Sputum: numerous acid fast bacilli.
6	36	Polish	22 days	Pulmonary tuberculosis with cavitation, all lobes. Tuberculosis of liver and adrenals. Severe malnutrition.	Yes	Hb 55%, WBC 6.650. Urine alb. 2 plus. Sputum: pos. for acid fast bacilli.
7	45	Polish	22 days	Pulmonary tuberculosis with cavitation, all lobes. Tbc of liver, spleen and kidney. Severe malnutrition.	Yes	Hb 65%, WBC 3,200, RBC 4,390,000. Urine neg.
8	49	Polish	3 days	Severe malnutrition with edema and heart failure.	Yes	None.
9	41	Polish	6 hours	Left and right heart failure, edema, anasarca, exhaustion.	Yes	None.
10	29	Russian	2 days	Severe malnutrition. Left empyema.	No	None.
11	25	Belgian	2 days	Sucking gun shot wound left upper chest 3 weeks old. Malnutrition, exhaustion.	No	None.
12	42	Czech	3 days	Dry gangrene, left lower leg and inner thigh. Malnutrition.	No	None.
13	51	Polish	3 days	Large dirty ulcer in rt. floor of mouth. Decubitus ulcer over left trochanter, intractable diarrhea.	No	None.
14	21	Russian	23 days	Bilateral pulmonary tuberculosis. Malnutrition.	No	Hb 60%, WBC 10,800.
15	21	Russian	16 days	Rt. pulmonary tuberculosis. Extreme emaciation.	No	Sputum: pos. for acid fast bacilli. Hb 60%, WBC 3,200.
16	26	French	1 day	Bilateral pulmonary tuberculosis; bilateral tuberculous epididymitis. Extreme emaciation.	No	None.
17	53	Yugoslav	7 days	Bilateral pulmonary tuberculosis with pleural effusion.	No	Urine negative.
18	21	Russian	3 days	Severe emaciation. Exhaustion. Chest X-ray: Bronchopneumonic infiltration left base.	No	None.
19	38	Polish	18 hours	Enteritis 4 months. Severe terminal diarrhea.	No	None.
20	31	Hungarian	6 days	Intractable diarrhea. Severe emaciation and exhaustion.	No	None.
21	23	Czech	20 days	Rt. pulmonary tuberculosis. Large ulecration over rt. scapula. Extreme emaciation and weakness.	No	Hb 50%, WBC 13,000. Urine neg. Sputum pos. for acid fast bacilli. Hematocrit 27. Plasma proteins 8.2.
22	27	Russian	28 days	Bilateral pulmonary tuberculosis. Congestive heart failure.	No	Not available.
23	20	Russian	31 days	Infected gun shot wound lt. thigh. Left pulmonary tuberculosis. Severe malnutrition.	No	Hb 60%, WBC 6,900. Sputum pos. for acid fast bacilli.

Mixed infections were common. The two cases of Salmonella enteritidis abscess are of particular interest.

Treatment was directed toward an improvement in the patients' general condition by good nursing care and adequate diet with vitamin supplements. Plasma and whole blood were available and were extremely valuable in the initial phases of treatment. Penicillin was valuable in many of the infected wounds and subcutaneous infections. It was not a substitute for adequate surgical drainage.

Except for a few small plastic procedures performed late in our stay at Dachau, surgical activity was limited to the incision and drainage of infected wounds and abscesses and the application of appropriate plaster splints and casts.

The accompanying table presents the pertinent facts concerning the twenty-three patients who died after admission to our wards.

Comment

Newspaper accounts of sick, displaced persons imply that they can be dealt with en masse. This concept is erroneous. Proper medical care always resolves itself into the examination, diagnosis and care of the individual patient.

In time of war, with atrocities and acute epidemic diseases rampant, the importance of tuberculosis is sometimes overlooked. Its ravages will be felt long after more dramatic events and epidemics have been forgotten.

Summary

We have presented a résumé of our medical observations at the Dachau Concentration Camp. The simple recording of these facts does not portray the sufferings of the patients, nor the unbelievable horrors of the camp. The human values are apparent, however, even in this factual report.

NEBRASKA REPRESENTATIVE MILLER PRAISES WORK OF MEDICAL SERVICES

The following statement, given by the Honorable A. L. Miller of Nebraska in the House of Representatives, is reprinted from the November 23, 1945, Congressional Record:

"Mr. Speaker, the record of the medical men and the medical service in this war is outstanding. It has never been equalled by any Army in any war. There were over 570,000 wounded in World War II, of whom 360,000 were returned to some type of duty. There were some 25,000 or approximately 4 per cent who died of wounds.

"In World War II, only six men in each 10,000 died of disease each year. This is a lower death rate in disease than that of civilians in the same age group here in the United States; yet these men lived in every part of the world under adverse physical and sanitary conditions. In World War I, 165 in each 10,000 died each year of disease, and these men were serving only in the United States and in Europe; the death rate in the Union Army in the Civil War was 712 per 10,000.

"The death rate from pneumonia has been reduced from 24 per cent in World War I to six-tenths per cent in this war. The death rate for meningitis has been reduced to 4 per cent in this war as compared to 34 per cent in World War I.

"I am sure, Mr. Speaker, that the Congress and the country can look with considerable pride upon this fine record of the medical service. There is no record in civil life or elsewhere to compare with this, and certainly a good job has been done in preventive medicine, as well as in the treatment of disease."—*News Notes*, No. 34, Office of Surgeon General.

ARMY DISCHARGES

According to the office of the Surgeon General more than 15,000 physicians have been released from the Army since V-E Day. An additional 15,000 have been made eligible for discharge, which will make a total of two-thirds of the physicians in the Army on V-E Day. Over 3,500 dentists have likewise been discharged from the Army since V-E Day and another 5,000 have been declared eligible for discharge. This will constitute 55 per cent of the 15,000 dentists in the Army on V-E Day.

New requirements provide for discharge of physicians and dentists over the age of forty-eight or after the completion of forty-two months of service, except for certain specialists whose services are required for the care of sick and wounded in Army General Hospitals.

Some 22,000 Army nurses have been discharged to date of the 57,000 which represented the peak strength of the corps. Twenty-seven thousand had formerly been qualified to return to civilian life and new regulations add an additional estimated 12,500.

NOTES ON THE HISTORY OF MEDICINE IN HOUSTON COUNTY PRIOR TO 1900

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(Continued from the December issue)

George Nye was born at La Porte, Indiana, on March 12, 1845. The medical school from which he was graduated is not known, but it is recorded that beginning in 1868 he practiced medicine for many years and that he was a member of the National Eclectic Association. The first scene of his work as a physician was Papillion, Sarpy County, Nebraska, and it was there he met Rose L. Maryatt, a graduate of Milton College, Wisconsin, to whom he was married soon afterward.

In 1874 Dr. and Mrs. Nye moved from Nebraska to New Albin, Iowa; from there in 1877 to Riceford, Spring Grove Township, Houston County, Minnesota; and in 1879 to the flourishing village of Caledonia a few miles northeast. Of their four children only two, Jennie May, aged six years, and Charles Jesse, aged two years, were living in the early eighties when the family was still in Caledonia.

As has been stated, there were other physicians in the village at the time of Dr. Nye's residence, notably, Drs. McKenna, O'Connor, Dustin, G. L. Gates, probably Castle and Freeman, and others in overlapping periods of practice, the exact years of whose presence in the community have not been determined. It is remembered by senior residents that Dr. Nye had his office at the corner of Decorah and Main Streets.

By 1883 a Dr. George Nye, who held Minnesota state exemption certificate No. 420-3, was practicing medicine in Hubbard County. He died in Park Rapids on May 10, 1918.

John S. O'Connor was born on March 2, 1816, in the County of Cork, Ireland, as were the other members of the immediate family. Of his several brothers and sisters, one brother, William, also came to the United States.

After John S. O'Connor had received his early education in the schools of Ireland, he studied at the University of Edinburgh, Scotland, and was a university student in England. On coming to America he entered Rush Medical College, in Chicago, from which he was graduated with his degree of Doctor of Medicine in 1858. Immediately afterward he began a medical practice in Illinois that was interrupted about three years later, at the outbreak of the Civil War, when he entered into military service. For the next three years he was Surgeon, United States Army, First Section, Third Division, Cumberland United States Hospital, at Nashville, Tennessee, and he was with his regiment on the battlefield as well.

In 1866, well prepared by formal training and by both civilian practice and military medical and surgical experience to meet the exigencies of a

heavy general practice in a pioneer region, Dr. O'Connor, a man of enterprise and energy, settled in Caledonia, to follow his profession and to open one of the first drug stores in Houston County. Like many another early physician, he had been educated in both pharmacy and medicine. The second drug store in the village was operated by C. P. Coe. It has been recalled of this period in Caledonia that on September 9, 1867, the village post office was empowered to issue money orders and that, a matter of record, Dr. O'Connor was the first person in the settlement, two months later, on November 9, to avail himself of that service. Caledonia, in the later sixties, had about 700 residents. There were many Germans, Norwegians, Irish, and other settlers, of English and Scotch descent, that had come in considerable numbers from New York and the New England States. With his fellow residents, among them a varying group of physicians, some of whom have been named in preceding sketches, Dr. O'Connor was influential in building up a thriving village in a rich farming community and with them he prospered, owning, in addition to his drug store, other property in the little town and also a number of farms near by. The coming of the narrow gauge railroad, in 1879, discussed earlier in this paper, brought the community new growth and stability.

John S. O'Connor was twice married. Of his first marriage, to Ann Starkey, a Canadian, there was one child, John O'Connor. After his wife's death, Dr. O'Connor was married on April 16, 1860, at Cresco, Iowa, to Julia Ann Farrell, who was born in Ireland on August 14, 1843. A trained nurse by profession, Mrs. O'Connor ably assisted her husband in caring for his patients. Of the second marriage there were ten children, most of whom lived into mature years: Mary O'Connor Everett, a teacher; Thomas, a teacher and owner of a newspaper; Jennie O'Connor Schellinger; William, an electrical engineer and contractor; Edward, an attorney and newspaper owner; Nellie O'Connor McQueen; Arthur, who was a senior at Rush Medical College at the time of his death in 1901; Christopher; Charles; and Fergus, a graduate of the Chicago Dental College in 1902 with the degree of Doctor of Dental Surgery.

Dr. John S. O'Connor died in Caledonia on October 11, 1880. For a considerable time after his death Mrs. O'Connor maintained the home in Caledonia and owned and managed the drug store. Long afterward, when the two-story building that had housed the store and the home of the family was being razed, a resident of the village who chanced to be walking near the site picked up a slip of paper that came fluttering down the sidewalk in the breeze; on it was printed, "Dr. J. S. O'Connor, Druggist and Surgeon, late of the U. S. Army."

A well-known member of his profession in the community and county, a Mason and a member of the Episcopal Church, Dr. O'Connor still lives in the memories of early residents of Caledonia, recalled for his forceful and interesting personality and for his professional service to the community. In the early years, when at seasons the roads were almost impassable, he traveled long distances on horseback, as did his colleagues, to see his patients in the outlying communities, conveying his drugs and instruments in leather saddlebags. Under more favorable conditions he used horses and buggy and then carried with him extensive professional equipment superior to the average of that day.

Among the pioneer physicians of his period Dr. O'Connor was unusual

in that he had and used a gift of writing to record in many essays and articles, unpublished, his observations and experiences in a widespread and varied practice. Of his manuscripts many, in 1943, were in the possession of his son, Dr. Fergus O'Connor, of Chicago, the only member of the family then living.

Christen K. Onsgard, one of the eight children of Mr. and Mrs. Knute Onsgard, both of whom were natives of Hallingdal, Norway, and among the earliest settlers in Spring Grove Township, Houston County, was born at the farm home on April 10, 1863. He acquired his early education in the local public and parochial schools and in 1884 entered the Eclectic Medical Institute at Cincinnati, Ohio, from which he was graduated in 1887, in the same class with his brother, Lewis K. Onsgard. Returning to Minnesota, he was licensed to practice in the state, receiving certificate No. 1460 (E), and opened an office in Spring Grove. After five years, however, he moved to Halstad, Norman County, Minnesota, where he remained until 1899, when he returned to southern Minnesota to establish himself in Rushford, Fillmore County. In Rushford for nearly twenty-one years he was identified with the community as one of its most constructive citizens and an able and progressive physician. In 1920 he moved once more to Halstad, where he spent the remainder of his life, in active practice until failing health forced his retirement in 1929. He died in Halstad on October 21 of that year. A more detailed account of his life is included among notes on the lives of physicians who practiced in Fillmore County before 1900.

Lewis K. Onsgard was born on a farm in Spring Grove Township on January 1, 1866. His father and mother, Knute and Bergit Larson Onsgard, natives of Hallingdal, Norway, had come to Minnesota in the early fifties and were among the first settlers in Houston County. Mr. Onsgard was the finest type of pioneer—thrifty, honorable and hard working, an intelligent and useful citizen, active in community affairs. A loyal churchman, he helped to build the Lutheran Church of the settlement. It was characteristic of him that he wanted to give his children the best that lay within his ability and means. Mrs. Onsgard was an ideal wife, a woman of unusually kindly disposition, ambitious and capable, a good housewife and a devoted mother. One of her special pleasures in later life was to make an exquisitely knitted bedspread for each of her eight children, who were: Lewis K., Christen K., Kari (Mrs. Gullings), Guro (Mrs. Traaen), Bella (Mrs. Evenson), Maria (Mrs. Gunvaldson), Ingeborg (Mrs. Thore E. Jensen) and Martin.

Lewis K. Onsgard received his preliminary education at the public and parochial schools of Spring Grove, working at the same time on the home farm and preparing even then for his future profession. His brother-in-law, Dr. Thore E. Jensen, husband of Ingeborg Onsgard, encouraged him and Christen to study medicine and to enroll at the college from which Dr. Jensen had graduated ten years earlier, and accordingly, in 1884, the brothers entered the Eclectic Medical College of Cincinnati, Ohio, from which, on June 7, 1887, they received together their degrees of Doctor of Medicine. Although Dr. Lewis Onsgard stayed on at the college for three months to take postgraduate work in ophthalmology, otology, rhinology, and laryngology, he at once applied for his license to practice medicine in Minnesota and on

June 22, 1887, received certificate No. 1461 (E), which three days later he filed in Fillmore County, which was to be the scene of his first practice. In addition to being a physician he was, also, like many other medical practitioners of the period, a registered pharmacist.

On his return from Cincinnati Dr. Onsgard settled in Harmony, Fillmore County, as he had planned, a location with which he was satisfied and in which he was successful. That he did not stay there came about through coincidence. On May 20, 1889, he was married to Anna Laugen, of Houston, an American of Norwegian descent, who was born at Broadhead, Wisconsin. Through his wife he became acquainted in Houston and came to know especially well Dr. Henry P. Johnson of that village. When, in 1892, Dr. Johnson decided to follow his profession in the city of La Crosse, Wisconsin, he persuaded Dr. Onsgard to take over his practice in Houston. The move to Houston proved to be an advantageous and happy one and Dr. Onsgard remained in the village forty-six years, until his death. As was common among physicians in those years, he had his office in his home. That he was a successful physician who possessed the confidence and esteem of his patients and of the community is not surprising, for he was trustworthy and conscientious and used good judgment based on sound knowledge. Although naturally serious he had a keen sense of humor, a trait that was appreciated especially by young folk and children, many of whom he helped through the stress of illness or injury by his timely little jokes.

In addition to carrying on a large local practice, Dr. Onsgard served on the staff of the General Hospital of Winona, Minnesota, and often was called in consultation with physicians elsewhere. He was a charter and affiliate member of the Houston-Fillmore Medical Club; a member, and its treasurer, of the Houston-Fillmore County Medical Society; a member of the Minnesota Valley Medical Association, which in 1911 joined with the Southern Minnesota Medical Association; the Minnesota State Medical Association and the American Medical Association. In his township and county he held various offices in which he untiringly gave of his ability for the welfare and improvement of the community. For many years he was a member of the local board of health; was coroner two years, from 1893 to 1895; county physician; and secretary of the local United States pension board. He was interested in fraternal organizations and was a supporting member and regular attendant of the Lutheran Church.

Early in his career Dr. Onsgard was appointed local company surgeon for the Chicago, Milwaukee, St. Paul and Pacific Railroad Company, a capacity in which he served until his death, and he was a member of the Congress of Railroad Surgeons. His service as railroad surgeon was the occasion of an unpleasant incident, unique in his practice, in which, however, he was exonerated completely. A railroad employe whom he had treated for an injury of the neck alleged that the treatment had not been the proper one and brought suit against the road. When he lost the case, he sued Dr. Onsgard for damages. Eventually the case came before the Supreme Court of the state, where it was thrown out. A pleasant occasion was one on which, when he had taken a railroad employe to Rochester for treatment, he was entertained at the home of Dr. Charles H. Mayo; young Charles, so small, that he was in a high chair, was at the family table. The friendly, kindly atmosphere pleased Dr. Onsgard and on his return home he commented, "That is a real American family." It amused him in later years to recall that once

when talking with the Mayo brothers he had told them that they would have to build an addition to their hospital. "Oh, no," they said, "we've got more patients now than we can take care of." Years afterward, at a meeting of the "four-county" medical society in Rushford, when the three men were reminded of the conversation, he was delighted when the brothers told him, "We had to build that addition after all."

Dr. Onsgard began his practice before the days of all-weather roads and powerful automobiles and his experiences were those of his fellow physicians throughout the region. In the first part of his medical career he kept five or six good driving horses in order to meet the demands of his practice, and when his own horses were weary from long hard trips he hired a team and driver from the livery stable. When automobiles appeared, he was one of the first to recognize their potential value to physicians and his Ford car was the first motor to be used in Houston, as his Snowmobile, for winter driving, was the first of its kind in the community. Perhaps his greatest general interest outside of his professional and civic work was to observe and to promote as much as possible the development of the highway system; and simultaneously with improvements in roads he followed with keen interest the steady improvement in automobiles. His immediate personal interest was in his farm, which always was managed efficiently. In his later years, one of his chief pleasures was to go for rides, in a comfortable automobile equipped with heater and radio, to the farm, and about the scenic countryside over which he had driven horses under all conditions of weather, in all seasons, day and night, when roads had been uncertain and often dangerous.

His friends and old-time patients tell of many of Dr. Onsgard's hazardous experiences in attempting to reach his patients. Two such occasions are noted here. In March, 1897, at a time when all the streams in the region were in flood, the doctor was called on a confinement case. As it happened, the patient had been moved to the home of friends who lived near the main traveled road so that she might be nearer medical aid, but the bridge on this road suddenly was washed out, leaving the house inaccessible except by boat. With two men at the oars Dr. Onsgard attempted the crossing. In the savage current the boat soon was out of control and rapidly was drifting close to the milldam. One of the oarsmen, in terror, threw off his coat and was about to plunge into the water to try to swim ashore and, with difficulty, was persuaded by Dr. Onsgard, who knew that no swimmer could live in that deadly flood, to take the oars again. After a desperate struggle they reached the bank and the doctor attended his patient. At a later period the occasion again was a confinement case, out on the South Ridge eighteen miles from Houston. It was winter, and when the driver and team called for Dr. Onsgard, a blizzard was raging, obscuring the houses on the opposite side of the street. They set out, nevertheless, and with great difficulty groped their way along the valley by following the fence posts and telephone poles. Finally, on the Ridge, they were about to give up in despair. The team was exhausted even though the two men had taken turns walking, and there was no sign of a road. At the moment when they had reached an abandoned cattle shed, where they would have taken poor refuge, they saw a light in the near distance. It proved to be in the home of a farmer, who hitched up his horses and took them to their destination, where they arrived just in time, for the patient was in convulsions. Always the physician, Dr. Onsgard forgot his

fatigue and discomfort. The mother and the baby boy lived, to the lasting gratitude of the family.

Dr. Onsgard died in Houston on October 24, 1938, of arteriosclerosis. He was survived by one brother, Martin; one sister, Mrs. Thore E. (Ingeborg) Jensen, both of Spring Grove; by his wife and all of their five children: Orrin C., a dealer in Ford automobiles at Houston; Agnes, a teacher of piano, who had a studio in the family home at Houston; Laura, Mrs. Axel Hanson, of Albert Lea, a graduate of St. Olaf College and a former teacher in the Albert Lea High School; Ruth, Mrs. P. F. Johnson, of Houston, a graduate of a teachers' college and a former teacher in the Houston schools; and Dr. L. Kenneth Onsgard, of Houston, a graduate of St. Olaf College and of the Medical School of the University of Minnesota. Dr. L. Kenneth Onsgard, who joined Dr. Lewis K. Onsgard in practice in 1929, has his father's surgical instruments and his fine medical library.

It is not strange that Dr. Lewis K. Onsgard was valued, respected and loved by his fellow citizens and that he is held by them in honored memory. The words of one friend, typical of many, express their regard:

> Perhaps no person outside the immediate family of the late Dr. Onsgard knew him as intimately as I. Being that during a period of twenty-three years I was a practicing druggist, and he my outstanding patron, we have much in common.
>
> He had a wonderful personality—kind, agreeable, and considerate—unusually mild in temper, and not once did I see him lose it. I never had a better and truer friend nor could a near and friendly relative have shown more interest in my success than he. He was strictly honest, not now and then, but always. That he was a successful practitioner is common knowledge and upon that I need not dwell. I shall always remember him as one who made my life more easily lived and enjoyed. Long live his memory.

Harry S. Piggins, a graduate, in 1885, of Rush Medical College, was certificated in Houston County in that year, having received Minnesota state license No. 1036 (R) on April 17. Record exists that in 1909 he was practicing medicine in Milwaukee, Wisconsin. It is hoped that more can be learned about him. In Caledonia, where he was in practice for several years, he has been described as a small man, dignified, a competent "doctor."

John Edwin Pope was born at Carroll, New York, on February 16, 1836, and died at Caledonia, Houston County, on January 19, 1909. A nephew of Dr. Timothy Arnold Pope, who was one of the earliest physicians in the county, John E. Pope in the sixties studied medicine under his uncle's preceptorship and thereafter practiced in Caledonia.

On October 23, 1859, John Edwin Pope was married to Betsy M. Woodward. Of the two children of the marriage, Charles Lineas and Eva Luella, the daughter, Mrs. Eva L. Evans, of Minneapolis, survived in 1941. The following excerpt from her letter of October 14, 1941, gives the clearest available picture of Dr. Pope:

> . . . I remember so little of my father as a physician. I was a little girl at that time. I can just remember a few instances of his going to or coming from calls, . . . of his having a very serious illness and his never being able to carry on his practice after that. I have been told that he was considered a very good physician in the community where he practiced. He belonged to the Methodist Church and was willing and glad to help in every way he could.

Timothy Arnold Pope was born in Otsego County, New York, on November 24, 1819, son of Jedediah and Lucy Angel Pope. When a boy of fourteen years, he moved with his parents to Chautauqua, in Chautauqua County, New York, in the extreme southwestern corner of the state. Two of his brothers were Jedediah and Gershom. The names of the other children in the family have not been learned.

In 1849 Dr. Pope was graduated in medicine from Western Reserve College, at Cleveland, Ohio, and in the following year he was married to Mary Abigail Howe, of Mentor, Ohio. Dr. and Mrs. Pope had four children, Laura Cornelia, Lucy C., Leon Dudley and Lida Edna. In 1941 the nearest living relatives of this pioneer couple were a niece, Mrs. Laura Barker, of Caledonia, Minnesota, and a grandniece, mentioned previously, Mrs. Eva Luella Evans, of Minneapolis.

Dr. Pope practiced medicine in Chautauqua County until 1854, when he moved with his family, in the exodus of hardy pioneers from the northeastern states into the Middle West, and settled in Houston County, Minnesota. They first made their home at Pope's Prairie, south of Caledonia, which had been named for Dr. Pope's brother, Captain Gershom Pope, who had preceded him into the county by a few months. The second brother, Jedediah Pope, also came into the region with his family in 1854.

In the spring of 1856 Dr. Pope took claim in section 13 of Yucatan Township and in that year was instrumental in having a post office established in the settlement that first was called Utica and later Yucatan. As noted earlier, he served as the first postmaster in Yucatan, but his duties did not prevent him from continuing his medical practice, managing his farm and serving as the first town clerk, a capacity in which he functioned for several years. In 1860 and 1861 he taught school in Sheldon. A year or so later he returned briefly to Yucatan, sold his farm and moved to the village of Old Houston. During his practice in that community he served as county coroner, in 1863 and into 1864, and acted as instructor in medicine to his nephew, John Edwin Pope.

Contemporary with Dr. Timothy A. Pope in Houston must have been Dr. P. T. Bowen. And, as has been noted, there were at the same time in various parts of the county, to name only those physicians who arrived prior to 1860, Drs. G. J. Sheldon, Alexander Batcheller, J. W. Albee, J. M. Veiling (Velling?), H. T. Fox, Charles Jenks, H. B. Train, T. R. Humphrey and perhaps H. B. Laflin.

Dr. Pope, evidently a true pioneer, in the early eighties left Minnesota for Iowa and later went to North Dakota, where he remained. He died at Grand Forks, on December 14, 1893.

De Costa Rhines was born on January 18, 1858, at Jackson, Michigan, the son of George Washington Rhines and Julia Lincoln Rhines, both of whom were natives of New York State. George W. Rhines was of Pennsylvania Dutch stock, his wife of English descent. Mr. Rhines served throughout the Civil War and his son, who was a very small child in 1861, has said that he first saw his father when the soldier returned home after the war.

De Costa Rhines attended the grade schools at Jackson and in 1882 was graduated from the local high school. In the summer vacations of this period he worked on the home farm; in the winters of 1880 and 1881 he combined his regular school work with the study of medicine under Drs. Towne and

Anderson of Jackson, so that by 1882 he was well prepared to enter the Hahnemann Medical College of Chicago, from which in 1884 he took his degree of Doctor of Medicine. Dr. Rhines' first medical practice followed immediately at River Junction, Michigan, where he remained only a few months before moving to Houston, in Houston County, Minnesota, in which state on August 18, 1884, he was licensed to practice, receiving certificate No. 937 (H). Houston was the scene of his activities for fourteen years. Politically independent, he identified himself throughout his career with the advancement of professional and community interests. For several years he was a member of the village council, for one year its president, and he also served as local health officer. In the late eighties he took Dr. Cassius S. Cranson, who previously had been in Sheldon, into association with him for about a year. Among the other physicians in Houston during his residence were Drs. H. P. Johnson and L. D. Onsgard (succeeding Dr. Johnson).

In 1898 Dr. Rhines took a postgraduate course at the Eye, Ear, Nose and Throat College and Hospital of Chicago and in that year, also, attracted by excellent opportunity in the village of Caledonia, he bought the practice of Dr. W. W. Freeman, who was moving to Grand Meadow. By 1899 Dr. Rhines had entered into his new field and here, as in Houston, he was a progressive physician and a leading citizen until his retirement from active practice in November, 1941, and his removal at that time to Owatonna, in Steele County, to make his home.

In Caledonia, Dr. Rhines served as local health officer and at one time as health officer for the Township of Brownsville also. He was county coroner in 1905 and in 1917 and, at the time of his leaving Caledonia, he again had been coroner for several years. He was president of the village council for two years; a member of the school board and of the commercial club; and during World War I he was chairman of the second, third, fourth and fifth Liberty Loan committees. He long has been a member of the Caledonia Chapter of the Masonic Lodge and of the Winona Consistory.

When the Houston County Medical Society was founded, at about the turn of the century, Dr. Rhines was a charter member, and he worked with the organization as it successively merged with the medical societies of Fillmore, Olmsted and Dodge Counties to form a four-county organization. At a meeting in Rushford of the Houston-Fillmore County Medical Society, in which he served as a censor, it was his privilege to propose as an honorary member his valued friend, Dr. Henry C. Grover, of Rushford, a veteran practitioner who had been "like a father" to him for years. Dr. Rhines has maintained membership in the Minnesota State Medical Association and in the American Medical Association.

On March 15, 1883, De Costa Rhines was married to Addie M. Peterson, of Jackson County, Michigan; their companionship has been unbroken. They have two children: Ray N. Rhines, manager of the Mechanical Department of the Northwestern Newspaper Company at Billings, Montana, and Hazell, at home, an able teacher, a graduate of the Winona Normal School.

Dr. Rhines has been distinguished by sound judgment in business. It has been a matter of personal pride and satisfaction always to own his own home. He has disclaimed hobbies, and it is obvious that his constructive work as physician and citizen has been his recreation as well.

(To be continued in the February issue)

EDWIN J. SIMONS, M.D.

President, Minnesota State Medical Association

President's Letter

PERHAPS, the first thing to be done in a letter such as this is to express a deep appreciation of the honor of serving as President of your State Medical Association. Then, too, with any such position come responsibilities which might be colossal and fearsome were it not for a feeling that you have always co-operated so wholeheartedly with the Executive Secretary and the personnel of his office, with the Council, with the Committee on Public Policy and Legislation, and with the other officers of the Association. It is this ever-present, harmonious, co-operative spirit on the part of all the physicians of the state which has given strength to the organization.

Also, initially, it is only fitting and proper to pay tribute to my immediate predecessor and those before him, to the members of the Council, to the various committee members, and to your other officers and State Office incumbents. Devotion to the duties of their several offices, self-abnegation, and perpetuation of high professional principles, have characterized their tenure in office. Always, the motivating force behind judgments made and actions taken by them has been the welfare of the patient-public and the best interests of the medical profession as a whole.

Thus, then, at this juncture, there is a sense of sincere gratitude, a realization of the challenge ahead, an appreciation of the abilities of preceding and present officers, and a feeling of loss that the enjoyable ties and associations at Council meetings and in other spheres of activity will slowly dissolve.

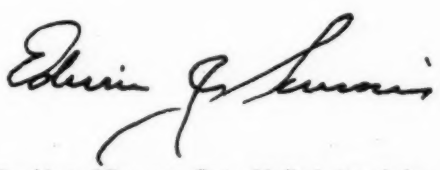
It is apparent that readjustment to peace is to be as hazardous as were the dislocations incident to war. Even now, integration of returning military physicians with civilian practice is our major problem. Its proper solution, mindful of needs and merits of our returning colleagues, is vital to the continued lofty level of civilian practice. This program is being jointly arranged by the Executive Secretary of the Association and the Director of Postgraduate Medical Education at the University of Minnesota.

Beyond this immediately pressing matter, two other questions present a challenge. The first requires that the standard of medical care not only be maintained but elevated proportionately with the remarkable scientific progress in various medical fields. And the second demands that medical minds be attuned to socio-economic changes in such fashion that from medical ranks will come the answer to trends toward government-controlled medicine. Preserving free choice of physician, the patient-physician relationship, quality of medical care, and the other basic features of the American System of Medicine, should be the keystone in any proposed new plan.

Bearing in mind these objectives, at this time when inventories are customary in the industrial and commercial world, an inventory of our accomplishments to date is warranted. The health of the civilians of the United States has never been better than it has been through the war years and now. Furthermore, military casualties, mortality and morbidity were never lower in any previous war than in American forces in the war just over. Thus, both civilian and military physicians can feel proud of the accomplishment of American medicine to date. This, however, should not lull us into a sense of complacency, but should spur us on to higher goals, including greater human longevity, still lower mortality, and continued advancement in all phases of scientific medicine.

Similarly, with all the public and political interest in health insurance and various forms of government controlled medicine, the Minnesota State Medical Association is keeping apace with social and economic departures in its Prepaid Medical Care Plan. Combined with this, undoubtedly will be evolved measures by which adequate, good, medical care will continue to be available to all of the people of Minnesota at a cost which they or the taxpayers can afford to pay.

So, with our house in fair order at the moment, with the objectives of the future clearly before us, let us continue working together in the same effective manner which has given us reasonable success in the past.



President, Minnesota State Medical Association

Editorial

CARL B. DRAKE, M.D., *Editor;* GEORGE EARL, M.D., HENRY L. ULRICH, M.D., *Associate Editors*

INCENTIVES IN PRIVATE PRACTICE AND STATE MEDICINE

LITTLE attention has been called to the fundamental differences in incentives under the systems of private medical practice and state medicine not only on the part of physicians but of patients.

In private practice the physician takes pride in his work. He strives to do his best in the making of a correct diagnosis and in prescribing the best possible treatment. Besides taking pride in his work, he knows that a medical practice is built up by the reference of new patients and by satisfied former patients. Satisfying patients is an art based on the rendering of thoughtful examination and prescribing. Some are lacking in the art to begin with and never acquire it. Some overdo the art and are weak in the application of scientific medicine. But, by and large, the physician has the incentive to give his best to his private patients. He charges what he believes his services are worth, and it is usually in line with that charged by his confreres. While he may adjust his charges one way or the other, depending on what he believes to be the financial status of the particular patient, his charges are as a whole rather uniform. He knows that overcharging will drive his patients away, whereas undercharging may give the impression of inferior service obtained.

The patient, on the other hand, seeks the services of a physician about whom he has heard a favorable report. And he seeks him generally because he is not well or at least thinks so. He is willing to part with a fee in order to obtain the advice he desires.

In state medicine, the physician's incentive is likely to be quite different, human nature being what it is. If he is paid a salary, he may still have the desire to retain that feeling of satisfaction from rendering his best, but his best is likely to sag if he sees little opportunity of obtaining advancement as a result of good work. If his financial compensation is not increased by the seeing of more patients, that incentive is gone. He will have little desire to accommodate patients as to time and place.

If the physician is compensated according to a fee schedule, the incentive will be present for unnecessary visits, and, if he collects for medicine prescribed, for useless medicine.

If, on the other hand, the patient is at liberty to visit a physician at any time of day or night at no cost to himself, he has no inhibitions on his demands for medical service, and the percentage of unjustified calls mount. Calls by neurotics would make practice unbearable. If the physician is paid under state medicine on a visit basis, there would be little incentive to discourage unnecessary visits.

Is it any wonder that in New Zealand where free physician service has been in existence in recent years and where any New Zealander may visit a physician as often as he likes and the doctor can collect a fee for each visit, that the cost has exceeded the calculated $5,000,000 a year by 50 per cent? This state of affairs is called racketeering. It is simply the inevitable result when people feel they can get something for nothing. Government leaders in New Zealand have reported that the present income taxes, which go as high as seven-eighths of all earnings, enable the Government to recover most of the money paid to such doctors. State medicine in New Zealand has proved expensive both from the government's and from the physician's standpoint. Consideration is being given to its termination. State medicine in the United States would result in the same experience.

THE PEPPER BILL AGAIN

THE Pepper Bill, as the Maternal and Child Welfare Act of 1945 is known, has been introduced in Congress and provides for complete medical nursing, hospital and dental care for maternity services and children up to the age of twenty-one, irrespective of ability to pay. The bill proposes to furnish this care essentially the way the EMIC program for GI wives and chil-

dren has been carried out through state agencies. The bill provides for choice of physician, and the physician may decline to care for the patient. Compensation would be according to a fee schedule or salary as determined in the states concerned. The cost will be met through federal taxation.

According to the most recent publication *(Briefs)* of the Maternity Center Association of New York, an organization devoted to promoting better maternity care in the United States, the Medical Board of this organization, after due consideration, has approved the Pepper Bill in principle and is making this opinion known to the Congressional committees concerned. They do, however, make two important suggestions: (1) that the age limit be fourteen instead of twenty-one; and (2) that consideration be given to restricting the benefits of the services provided under the bill to those who cannot pay for adequate high quality care.

The Pepper Bill, as submitted to Congress, constitutes state medicine for obstetrics and pediatrics and for youth up to manhood and womanhood. The medical profession is opposed to the replacement of private practice including obstetrics and pediatrics by state medicine.

If the Pepper Bill is modified to apply to the medically indigent only, quite a different proposition is presented.

That a certain number of mothers and children lack medical and dental care is a fact. This is due to a variety of factors. Some cannot afford it. Others live in districts unable to support physicians and dentists. Some spend their income on less essential things. With some, the cost of catastrophic illness is entirely beyond their means without the aid of insurance. Hospital and medical prepayment insurance will do more and more as they expand to provide medical care for the low-income group and will lessen the number of families who could be classed as medically indigent.

No matter how much voluntary prepayment medical and hospital insurance expand, there will still be a medically indigent group. These are being provided for by numerous tax-supported and charity organizations, not to mention the free or reduced fee services rendered by physicians individually.

The actual need for greater assistance for this group is doubtless exaggerated by would-be reformers. Certainly, the need is not so great as to justify the entire socialization of obstetrics and pediatrics with the establishment of another bureau in Washington. Even if the Pepper Bill is modified to provide for the medically indigent alone, the question arises as to the use of federal funds for such a purpose. Meeting such a need by the local units of city, county and state is likely to be less expensive. After all, federal subsidies are raised by federal taxation and are not in the nature of a gift.

The care of mothers and children presents a strong emotional appeal. This does not mean that there should not be a realistic approach to the problem which is local and should be solved locally.

DR. SHOULDERS TO LEAD BATTLE OF FREEDOM

There is a splendid timeliness in election of Dr. Harrison H. Shoulders to presidency of the American Medical Association, for American medicine is facing the challenge of socialization, and Dr. Shoulders has been in the forefront of the fight against that hazardous challenge.

Leaders in the medical profession know the dangers invited by political control of medicine, however glibly its advocates dress it in words of innocence. As speaker of the AMA's house of delegates, and throughout his service in the Tennessee Medical Association, as member, secretary, and editor, Dr. Shoulders has led an uncompromising fight for the freedom of medicine from such political encumbrance, and he will bring to this new assignment the same unswerving defense of freedom's safeguard.

Dr. Shoulders will take office next year, but the fact doesn't abate the force of his immediate fight, and the American Medical Association's. They have mobilized for it; obviously are recruiting leadership of maximum stature, and command thereby the faith of the American public whose welfare is at stake. It is hardly likely that thinking American citizens will prefer political voices to authoritative, medical voices on a subject involving life and health. It is inconceivable that thinking citizens will permit subjection of MEDICINE to the principles of boondoggling, or assign it to the arrogant, untender mercies of bureaucracy.

Dr. Shoulders has earned the faith of his vast constituency, not only for professional skill, but for vision incorporating those standards and principles of medical freedom enabling American medicine to forge ahead in a field of science whose boundaries must remain beyond the reach of government dictation. As such a leader, his opinion will bear weight with the people. In this fight, his service again is to his country, no less than when he wore his country's uniform against another, external enemy.

The American Medical Association is to be congratulated for choice of such a leader; Dr. Shoulders for the opportunity conferred; the country for possession of such leaders for the defense of principle at home.—*Nashville Banner*, Dec. 6, 1945.

MEDICAL ECONOMICS

Edited by the Committee on Medical Economics
of the
Minnesota State Medical Association
George Earl, M.D., Chairman

NEW ERA IN VETERANS MEDICAL CARE SEEN

It is becoming increasingly apparent to politicians who would like to be on the receiving end of some pork-barrel doles relative to veterans hospital sites that times have changed and that the new Veterans Administration meant business when it announced a policy of situating veterans hospitals solely on the basis of what will best promote the health and rehabilitation of the veteran.

Both Major General Paul R. Hawley, Medical Director of the Veterans Administration, and his Chief, General Omar Bradley, are grimly insistent that areas that are medically strategic, not politically important, are to be selected.

In line with this policy, of the nineteen new hospitals providing for 11,100 beds to be available by June, 1946, thirteen are to be located near medical schools. This is intended to make available the part-time services of specialists where they will be most readily accessible—near teaching and more populous centers.

Minnesota Plans Shaping Up

A joint announcement last month by Dr. Harold S. Diehl, Dean of the Medical School of the University of Minnesota, and Mr. Carl D. Hibbard, regional Veterans Administrator, revealed a plan, one of the first of its kind in the country, under which University Hospital physicians will be sent to the Minneapolis Veterans Hospital. The revamping of the medical services there and the supplement of professional services to ease the physician shortage existing at the present time, will result in providing veteran-patients with medical care that will be on par with that offered in any private institution in the state.

In the deficiency appropriation bill before Congress, approved by the Senate last month, are included plans for a 200-bed veterans hospital in southern Minnesota, estimated to cost $2,655,701, to be used for tuberculosis treatment; and a similar sized hospital in Duluth, at an estimated cost of $2,497,751, for general medical and surgical treatment.

New Hospital Administrator Minnesota Man

Recently named administrative head of Veterans Administration hospitals for the entire country was Lt. Col. Harry E. Brown, who served for ten years prior to his being called to duty in January, 1942, as superintendent of Northwestern Hospital in Minneapolis. In addition to directing hospital planning and business administration, he will be in charge of selecting new hospital sites, acquisition of beds in civilian as well as Army and Navy hospitals and taking over Army and Navy hospitals declared surplus.

The majority of these institutions, as well as the new units being planned, are to be devoted largely to domicile the so-called "long stay" patients—the nervous and mental cases, the cardiac cases, the tuberculous and those requiring specialized services.

Outpatient Care a Local Problem

At the AMA House of Delegates session last month, Major General Hawley, speaking before the delegates, placed the responsibility for the development of a program for veteran outpatient service, satisfactory to physicians and the Veterans Administration, squarely up to the State Medical Societies.

Stressing the problem of outpatient care, Dr. Hawley stated that the Veterans Administration would like to have every physician in each community designated as a veterans physician. In this way, the veteran gets his medical care just as any other member of the community does—from

a physician of his own choice, and not, as in the past, from one or two designated physicians in the community.

No set scale of fees is contemplated, Dr. Hawley said. The program is to be operated on the premise that these will vary with states and it will be the duty of the State Medical Societies to determine equitable fees in their respective states.

Welcome news to physicians is the promise that administrative work will be kept to a minimum by simplification of forms that have to be filled out. It is planned to assist the busy physician by staffing suboffices with clerical help to handle the bulk of their paper work.

At a meeting of the Council of the Minnesota State Medical Association on December 16, a committee was appointed to work with the Veterans Administration here to develop a plan for Minnesota that will meet with approval both of the Veterans Administration and the physicians in the State.

MINNESOTA CIVILIAN HOSPITAL FACILITIES UNDER SURVEY

Even as United States senators were readying themselves for passing, with relatively slight modifications, the original Hill-Burton Hospital Construction Bill, the governor-appointed members of Minnesota's Hospital Survey Committee were discussing ways and means to speed the state-wide survey that would make funds available for hospital construction here. The survey was directed into the capable hands of Dr. Viktor O. Wilson, Director of the Division of Child Hygiene of the State Health Department, under whose direction the Minnesota Hospital Licensing program has functioned remarkably well since its establishment by legislative act four years ago.

Supplementing the considerable data compiled on Minnesota hospitals under this program, are extensive statistics in the files of the executive office of the Minnesota State Medical Association as a result of on-the-ground surveys of health facility needs conducted by Minnesota physicians a year and a half ago.

Under the provisions of the Hill-Burton Bill, once the survey is completed, the state agency designated to handle the program would set up a plan for hospital construction designed to provide facilities on as wide a scale as possible. This plan would be submitted to the surgeon general for approval together with facts regarding financial sources available from state or local sources, which determines the extent of the federal grant.

To date some sixty communities are planning new hospitals or additions, involving an expenditure in excess of $40,000,000 for the next five years. Plans for these will go ahead even without federal aid. However, if the bill is passed, a large expansion to present plans is held likely.

Facts have come to light recently that certain ambitious public officials have grabbed at the chance to make headlines by importing, by invitation, personnel from the United States Public Health Service to conduct independent surveys of individual hospitals. This would certainly not appear to be in conformity with the bill which specifically provides for an over-all survey.

A PERSPECTIVE OF COMPULSORY HEALTH INSURANCE

President Truman's compulsory health insurance proposal fits perfectly with the social ideas of those who believe that government should undertake to protect all humanity against all the ills of existence at public expense. However, thoughtful people join the medical profession in viewing this whole idea of governmental supervision of medical care with a great deal of skepticism based on past performance in recent years of government intervention in many private fields. Indisputable evidence, demonstrated on many fronts, indicates that governmental bureaucracy tends to produce mediocre performance, and to discourage inventiveness and new ideas, all of which is inimical to scientific progress. American medicine, on the other hand, has achieved tremendously because every medical man is stimulated to do his very best by the prodding of his own conscience, by the constant competition within his own profession, by the knowledge that his earnings from his practice are not guaranteed by anybody and must be earned by his own initiative and skill.

While the matter of cost never seems to be given serious consideration in these days of billion dollar federal budgets, the fact remains, according to reliable medical statistics, that the President's proposed tax of four per cent on all incomes up to $3,600 a year to pay the cost of compulsory health insurance for everybody is in

excess of what families are paying today for all they need of the very best medical care.

The matter could well resolve itself into less health at more cost if one is to judge by the results in nations where compulsory health insurance has existed for many years.

New Zealand Offers Typical Example

Take the case of New Zealand, where free medical service is provided for all its citizens. According to a report published in the *New York Times* for October 7, the increasing annual cost of medicine has been alarming the Health Department for the last three years. Because of widespread abuses, the government of New Zealand is seriously considering the discontinuance of the present plan whereby any New Zealander is permitted to consult any physician as frequently as he likes, and the doctor collects the fee for each visit from a government fund. Abuses cited include "overconsultation" and speedy examination of patients, some at a rate of twelve an hour.

New Zealand's experience would seem to indicate that when the so-called "financial barrier" between the patient and doctor is completely removed or reduced to negligibility, the patient will consult the doctor for the most trivial or imaginary complaints. As for the doctor, when the time spent in unnecessary medical work is added to the time spent in reporting services and claims for services to the central authorities, there is little time left for attendance upon the patients who really need extensive care and treatment.

Furthermore, during the period when a great many New Zealand doctors were still in the armed forces, payments to civilian physicians were fifty per cent higher than the five million dollars a year which the government calculated would cover the total annual peacetime cost of the program. It appears now that the government would like to place all physicians on the basis of a fixed annual salary or retaining fee.

Immediate Action Necessary

It seems safe to predict that the majority of the physicians returning from the service will join their colleagues on the civilian front to frown on President Truman's proposed plan because they have had enough government control for a while and want to be free to practice on their own. And what about veterans? Employed veterans with service-connected disabilities, who are already entitled to medical care, are certainly not going to look favorably on paying extra for help which they already rate.

This is no time to merely sit back with objections and rejections, however vociferously they are voiced. It is rather a time to mobilize all forces of organized medicine to speed the development of a specific national health program with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by medical societies as approved at the House of Delegates of the American Medical Association last month.

The subcommittee of the Council on Medical Service and Public Relations appointed at that time to shape up a national plan should be expected to function without delay.

MEDICAL CONTINUATION COURSES

The University of Minnesota Center for Continuation Study has announced a series of courses for graduates of medicine whose plans for continuation education were interrupted by military service. The courses of study have been arranged for physicians who plan to accept an association with a specialist, obtain a residency, prepare for American Board examinations or return to practice.

Classes will be taught at the Center for Continuation Study, Medical School, University of Minnesota Hospitals, Minneapolis General Hospital, Ancker Hospital, Saint Paul, and affiliated teaching institutions.

Distinguished teachers from other medical centers will join the faculties of the Medical School, other University Departments and the Mayo Foundation to teach these courses, scheduled to begin January 4.

The following courses will be offered, with others to be announced later:

- Continuation Course in Medicine—January 4 to March 30, 1946
- Continuation Course in Basic Sciences—January 4 to March 30, 1946
- Continuation Course in Otolaryngology—January 14 to 18, 1946
- Continuation Course in Pathology of Diseases of the Skin—January 21 to February 20, 1946
- Continuation Course in Hospital Administration—January 21 to 25, 1946

Continuation Course in Basic Sciences (concluded)—April 8 to June 29, 1946

Continuation Course in Surgery—April 8 to June 29, 1946

Anyone interested in securing further details may address correspondence to the Center for Continuation Study, University of Minnesota, Minneapolis 14, Minnesota.

MINNESOTA STATE BOARD OF MEDICAL EXAMINERS

Julian F. Dubois, M.D., Secretary
230 Lowry Medical Arts Building
Saint Paul, Minnesota

Minneapolis Woman Ordered to Serve Two-Year Sentence for Narcotic Law Violation

Re State of Minnesota vs. Florence B. Brooks

On November 7, 1945, the Hon. Paul S. Carroll, Judge of the District Court of Hennepin County, revoked a stay of sentence entered on December 14, 1944, and ordered Florence B. Brooks, thirty-eight years of age, 1819 Bryant Ave. No., Minneapolis, taken to the Women's Reformatory at Shakopee, to serve a sentence of two years. The defendant entered a plea of guilty in the District Court of Hennepin County on December 14, 1944, to an information charging her with the crime of illegally possessing narcotic drugs. She had been arrested on November 4, 1944, by agents of the Federal Bureau of Narcotics immediately after having left the office of a Minneapolis physician who had furnished her with sixty ¼-grain Morphine Sulfate hypodermic tablets and twenty-five ½-grain Morphine Sulfate hypodermic tablets.

At the time Judge Carroll stayed the execution of sentence, the Court ordered the defendant to take treatment for her drug addiction. The treatment lasted three days and the defendant soon reverted to the use of various derivatives of opium. Through the excellent work of Mr. Howard R. Hush, Chief Probation Officer of Hennepin County and Mrs. Elvera M. Springer, Probation Officer, Mrs. Brooks was brought before Judge Carroll for violating the conditions of her stay of sentence, with the result that on November 7, 1945, Judge Carroll made an order revoking the stay. The defendant has been taken to the Women's Reformatory where she is now serving her sentence.

Fake Doctor Sentenced for Hospital Robbery and Car Theft

Re: State of Minnesota vs. John R. Kahl
Re: United States of America vs. John R. Kahl

On September 18, 1945, John R. Kahl, twenty-five years of age, 1610 Roblyn Avenue, Saint Paul, Minnesota, was sentenced by the Hon. Robert V. Rensch, Judge of the District Court of Ramsey County, Minnesota, to a term of one to ten years at hard labor in the State Prison at Stillwater, Minnesota. Kahl had pleaded guilty on that date to an information charging him with the crime of grand larceny in the first degree, following the theft by Kahl of money and jewelry in excess of the value of $500 from physicians and surgeons at a Saint Paul Hospital.

On October 9, 1945, Kahl was brought back from the State Prison at Stillwater, and taken to the United States District Court in Minneapolis where he entered a plea of guilty to three indictments charging Kahl with unlawfully transporting, in interstate commerce, three stolen automobiles. On the first charge Kahl was sentenced by the Hon. Matthew M. Joyce to a term of five years in a prison to be designated by the Attorney General of the United States, the sentence to commence after Kahl has served his Stillwater Prison sentence. Judge Joyce also sentenced Kahl to a term of three years for the second case, this sentence to commence immediately on the termination of the five-year sentence also imposed by Judge Joyce. On the third charge, Judge Joyce suspended the imposition of sentence for three and one-half years, Kahl to be on probation following his release from Federal Prison.

Kahl has a long criminal record dating back to when he was ten years of age, at which time he was first arrested at Boone, Iowa, for theft from a doctor's office. In September, 1933, Kahl was sentenced to the Red Wing Training School for burglary committed in Saint Paul. In June, 1935, Kahl was again returned to Red Wing on a charge of burglary. In September, 1938, Kahl was indicted by a Federal Grand Jury in Saint Paul on two charges, the first one alleging that Kahl stole a letter from a United States mailbox and the second one charging Kahl with escaping from the Ramsey County Jail where he was held while awaiting action of the grand jury. Kahl was given a total sentence of six years by the Hon. Robert C. Bell, Judge of the United States District Court. Kahl was first taken to the Federal Reformatory at El Reno, Olahoma, but was transferred from Leavenworth to the Federal Prison at Sandstone, Minnesota, where he served until June 6, 1945. Following his release, Kahl obtained work as an orderly at a Minneapolis hospital. This undoubtedly gave him the background for his entry to the hospital in Saint Paul where he committed the theft that led to his ten-year Stillwater sentence. Kahl has no training or education in the field of medicine.

IT'S NOT A CONSPIRACY

The idea persists in the minds of a few irreconcilables in the medical profession that Blue Cross plans are engaged in a sinister plot to grab control of the profession. Some even believe that hospital administrators are using Blue Cross as a tool to gain this evil end themselves.

For example, a recent issue of the *Bulletin* of the Winnebago County (Illinois) Medical Society publishes this statement attributed to an insurance executive: "I have made a rather comprehensive study of the Blue Cross history in an attempt to ascertain their present and ultimate goal, and it has become quite obvious to me that they intend to dominate not only the field of hospital insurance but also the field of surgical and medical care eventually."

In the same article, the past president of a state medical society is quoted as saying: "As between domination by the federal government and domination by hospital administrators, I think I should prefer the former. Unless we are very careful indeed, we are apt to find hospitals dictating the practice of medicine."

Of course, no one can say what is in the mind and heart of every last hospital administrator and Blue Cross executive in the country, and it may be that there are a few whose ambitions soar unreasonably toward widening powers. But every informed person will recognize as fantastic the implication that there is any general plan or intention in this direction. Unfortunately, many doctors who read statements like these in their medical society bulletins are unable to distinguish between fact and fabrication; they have had neither the time nor the interest to know better. Instead, they accept this fiction as truth and pass it on, thus unwittingly contributing to the conflict and suspicion that still delay decisive action toward a national voluntary health plan.

Publication of this fairy tale is as harmful as it is irresponsible. It ought to be stopped.

—*Modern Hospital*, December, 1945

Minneapolis Surgical Society

Stated Meeting held October 4, 1945

The President, Robert F. McGandy, M.D., in the chair

EMBOLISM OF THE RIGHT FEMORAL ARTERY

Report of Case

H. E. HOFFERT, M.D.

Minneapolis, Minnesota

This report is that of a white man, sixty-five years of age, who has had a long cardiac history. As a youth he had had rheumatic fever which left him with a double mitral lesion and which caused him to limit his activity to some extent thereafter. Twenty years ago on the advice of his physician he had begun taking 1 grain of digitalis twice weekly, a practice which he followed continuously without further checkup. Two years ago he suffered what was assumed to be a mild cerebral accident from which his recovery was complete, without seeking medical advice. He has been aware of irregular heart action for the past ten or twelve years. During the past year he had been feeling unusually well and had been working daily as a salesman for a paper supply company.

His present complaint began on February 18, 1944. For a week preceding he had had an upper respiratory infection but arose on this date feeling very well. At 8:40 that morning while shaving, he became aware of a tingling sensation in his right foot which was followed shortly by a persistent agonizing pain in his foot and lower leg. He was unable to move the foot on the ankle and could not secure any relief by changes of position.

He was seen at 9:30 a.m. when examination revealed an irregular heart with a pulse deficit of 18, blood pressure 160/90. The right foot and distal half of the leg were blanched and cold. The dorsalis pedis, ankle and popliteal pulsations were absent and the femoral pulse diminished as compared with the opposite extremity.

A tentative diagnosis of embolism of the right femoral artery was made and arrangements for transportation to and admission in Asbury Hospital carried out. He was given morphine sulfate grain ¼ from which he secured only partial relief.

Upon his admission to the hospital it was noted that the initial pallor of the lower leg and foot was beginning to be replaced by cyanosis and the femoral pulsation was still less prominent.

Laboratory studies showed his hemoglobin to be 105 per cent, white blood count 12,500 and urinalysis negative. An electrocardiogram was interpreted as showing an auricular fibrillation, myocardial damage and coronary disease.

He was seen in consultation with Drs. A. E. Cardle and S. R. Maxeiner, and immediate surgery was advised.

Operation: 500 c.c. of citrated blood and 100 milligrams of heparin for intravenous administration were in readiness.

Under local infiltration anesthesia an incision 4 inches in length was made directly over and parallel with the proximal portion of the right femoral artery. The artery was exposed and mobilized. There was no visible or palpable evidence of pulsation. A small longitudinal incision was made in the vessel after two small rubber-covered clamps had been passed loosely on the artery above and below the site of incision. A size 12 French catheter attached to a 20 c.c. syringe was then passed gently into the artery, distal to the opening, and aspiration showed no evidence of occlusion below this point. The catheter was then passed proximally, aspirating and advancing it cautiously. On the third attempt an embolus 3.5 inches in length was withdrawn and its removal was immediately followed by a very forceful gush of blood, which was controlled by gentle pressure with the rubber-covered clamp. The incision in the artery was closed using interrupted sutures of fine silk, care being exercised to avoid penetration of the intima. The clamps on the vessel were removed and it began to pulsate actively. It was kept under observation for eight to ten minutes, and after no diminution in pulsation occurred, the wound was closed and a pressure dressing applied.

Postoperative medication consisted of morphine sulphate grain 1/6 as indicated for pain, papaverine grain ½ every four hours, and heparine 20 milligrams intravenously every four hours for forty-eight hours, which resulted in a venous clotting time of 9 minutes and 30 seconds at the end of 24 hours, and 20 minutes at the end of 48 hours. Dicumerol 300 milligrams was given orally on the first postoperative day and 200 milligrams on the second which resulted in a reduction of the prothrombin time to 20 per cent of normal on the third postoperative day. During the following seven days this reduction was maintained by the additional administration of 100 milligrams of dicumerol on two occasions, daily prothrombin determinations being done.

The postoperative course of this patient was entirely uneventful. Six hours after operation the extremity was warm, the cyanosis was clearing and the popliteal pulsation was full and strong. The dorsalis pedis and tibial pulsations were present twenty-four hours later. His wound healed primarily and he was discharged walking on the fifteenth postoperative day.

Since operation he has remained under the constant care of Doctor Cardle and has been carrying on his work as before.

On September 23, 1945, nineteen months after his embolectomy, this patient suffered another arterial occlusion in the right lower extremity. He did not report this incident until fifteen hours later and by that time the appearance of the leg was such and the condition of his heart so grave that attempted embolectomy was not deemed justifiable. He is at the present time in Asbury Hospital undergoing a tourniquet amputation of the right leg. His condition at the present time is rather poor.

Discussion

DR. DANIEL MACDONALD: How soon after initial symptoms was the operation performed?

DR. H. E. HOFFERT: Symptoms started at 8:40 in the morning and the operation was begun at 2:40 in the afternoon.

DR. MCDONALD: How long was dicumerol kept up?

DR. HOFFERT: He received 300 milligrams on the first day, 200 on the second, and the prothrombin time was reduced to 20 per cent of normal. Daily prothrombin time was never above 20 per cent of normal. Only 200 additional milligrams of dicumerol were given during the subsequent week. After that it was discontinued.

LUMBAR SYMPATHETIC BLOCK AND THAT POSTPHLEBITIC LEG

H. O. McPHEETERS, M.D.
Minneapolis, Minnesota

Doctor McPheeters presented a paper on "Lumbar Sympathetic Block and That Postphlebitic Leg."*

He discussed the theory and principle of the lumbar sympathetic block and how it should be of value as an additional therapeutic aid in the healing of the chronic trophic skin conditions that follow in the wake of the deep thrombophlebitis of the lower extremity.

The Ochsner method was advised and 1 per cent novocaine was the solution injected. It was not advised as a permanent cure, but only as a helpful adjunct in the healing of the otherwise intractable and chronic trophic state of the lower leg.

Four separate case reports were given, demonstrating the help and value of the lumbar sympathetic block for this condition.

Discussion

DR. F. R. HIRSHFIELD: Isn't there potential danger of an embolism there when you relax the vessels of the extremity by blocking?

DR. MCPHEETERS: Therapeutically yes, but as Doctor Hoffert suggested in his case, all cases should be given heparin followed by dicumerol to reduce prothrombin time to 20 per cent of normal. Therapeutically you are supposed to increase the possibility of embolism, but practically you do not. I merely mentioned the deep femoral ligation. This treatment of thrombophlebitis has spread throughout the country and I predict it will recede to the background in less than ten years.

*See page 43 for complete paper.

DR. EARL C. HENRIKSON: I wonder whether it would not be better to get the patients up the fourth or fifth day, even if signs of phlebitis are developing, since by so doing we are dilating the blood vessels and stimulating the circulation by physical exercise which is what we hope to do when we do a therapeutic block. I know that most surgeons have felt that the patient would have to stay in bed longer when developing a phlebitis rather than that they should get up earlier.

DR. MCPHEETERS: During my visit in Brooklyn last winter I heard prominent obstetricians say they got their postpartum patients up on the fifth day. Some surgeons urge their appendectomy patients to get up on the second day postoperative.

Patients sometimes have more chance of dying by lying in bed. Their chances are better by getting up. My routine is to apply hot wet packs at a temperature of 130 for four hours at a time. The patient then is up and walking about one-half hour followed by the application of the hot wet packs.

THE TREATMENT OF NEUROSURGICAL CASES IN AN OVERSEAS HOSPITAL

WALLACE P. RITCHIE, M.D.
Saint Paul, Minnesota

The treatment of cases in the Army given by any one doctor or group of doctors depends to a great extent, not only on the situation and type of hospital in which the doctor is located, but also on the tactical situation presenting itself.

It will be well, therefore, to briefly describe the locations in which the 26th General Hospital was situated. The two locations in which the 26th General Hospital found itself were very different, not only as to housing, equipment, and place, but also as to the tactical problems.

While in Africa, the hospital was set up during the last six weeks of the Tunisian Campaign, the Sicilian Campaign, and the early part of the Italian Campaign. At no time was the actual front less than 150 miles away and in only a few instances did cases arrive without primary treatment. The casualties for the most part were ground force troops. A policy of evacuation was such that patients were not held for more than thirty to sixty days.

The Italian setup was different in many ways. The situation was more stable. The hospital was one of six assigned to the 15th Air Force, which comprised from 90,000 to 120,000 personnel and was large enough so that patients would not have to be evacuated to make room for other patients. The number of casualties arriving at one time was never large, and as a general rule no patient suffered because of lack of time.

It was an ideal location, as not only were casualties treated primarily (although small in number), but definitive treatment could be carried out. Furthermore, all of the diseases and conditions usually arising in a community of over 100,000 were encountered.

The equipment furnished by the Army was entirely adequate. In the early stages an electro-surgical unit,

brought over by the unit, was the only one functioning in Africa, but it was not long before others became available.

In Italy, we were furnished a quantity of fibrin foam and fibrin film.

Fibrin film was used in ten cases and the only observed results were not satisfactory. It had been advocated especially as a covering for dural defects. We used it only once for this purpose. The wound became infected. The film extruded and the patient developed a meningitis. In eight other instances it was used as a covering of a nerve and in one as protection of a tendon. The latter became infected. This was not the real reason for our discouragement in its use.

A patient, whose slide you observe, was shot in the upper arm by a rifle bullet, on October 2, 1944, suffering a complete section of the ulnar nerve. On October 23, 1944 (21 days later), the left ulnar nerve was sutured and a cuff of fibrin film placed around the nerve. On February 26, 1945 (125 days later) he returned for examination, and there was definite evidence of regeneration. There was, however, such a large mass of scar tissue beneath the operative scar that the wound was reopened and the scar removed from around the nerve. Shortly after this we received information that others had also noted the excess of scar tissue after the use of fibrin film.

Fibrin foam, however, lived up to its predictions, as being an ideal hemostatic. We used it in about fifteen instances and found it controlled bleeding well. In one instance it was packed in the lateral sinus. In another, it was packed into a rent in the dura in the region of the cribiform plate, as exposure was inadequate for suture. Cerebral spinal fluid leakage immediately ceased and no rhinorrhea developed. Lyle Hay controlled severe bleeding from an ulcerated rectal mucosa by packing the foam against the bleeding area. Its use for controlling liver and kidney hemorrhage is easily visualized.

The penicillin supply was adequate and was used to advantage in abscess cavities and in three of our patients who developed meningitis. Penicillin used in strength of 1,000 units per c.c. 10,000 units every six hours (sixteen times in one, ten times in another, and seventeen times in the third), undoubtedly aided in recovery. In one instance meningitis developed in spite of the use of intramuscular penicillin for six days prior to the onset of his illness.

Wounds of the Head

The principles laid down by Cushing, in 1917, of thorough debridement of penetrating wounds of the brain, was the foundation of the treatment of this type of wound.

Peter Ascroft, of the British Forces, was the first person to have a wide experience in this type of surgery, and his early reports aided the Americans in establishing their policies. At the very outset it was found that an early inadequate debridement was not as valuable a late adequate procedure, although the best results were obtained by an early operation. A delay of even seventy-two hours was deemed advisable if facilities in the form of equipment and personnel were not adequate before that time. With our system of Auxiliary Surgical teams and well staffed evacuation hospitals close to the point of injury, such a lapse of time was rarely necessary. In the particular instance of our hospital, the interval between time of injury and operation was on an average eight hours.

The cases of penetrating wounds we received were the ideal type to handle, as they occurred in men who were relatively clean to begin with and they were flown directly to a field only twenty minutes from our hospital.

The procedure in handling a penetrating wound of the brain was as follows: As soon as admitted, the patient was examined for shock and hemorrhage. If he was in good condition, he was taken to the x-ray room where x-rays were taken. Stereoscopic films are a valuable aid in locating bone chips. The patient was then as a rule placed in bed where he was given a chance to stabilize himself from the physical and mental excitement of the last few hours. At the outset we felt it important to rush the patient to the operating room but in only exceptional instances, when hemorrhage is uncontrolled, is this necessary.

After this stabilizing period of a few hours has passed the patient is taken to the operating room.

The choice of anesthesia is variable among the surgeons. Local anesthesia, except in the deeply comatose patient or the extremely co-operative patient, was never very satisfactory in my hands. We frequently used pentothal but in several instances were disturbed by severe laryngeal spasm, which required redraping. As a general rule, we used intratracheal anesthesia in all but the most simple procedures.

The wound edges were excised, a fundamental principle in the treatment of all war wounds. A thorough debridement of all the missile tract was then carried out. In our cases craniotomy was never necessary. Adequate exposure of the brain tract could be obtained through enlarging slightly the entrance defect. It was seldom necessary to enlarge the defect already present in the dura. The most important step was the removal of all bone fragments. Aschcroft demonstrated at an early stage that retained bone was the chief factor in the formation of abscesses, while retained metal fragments had little influence on the development of abscesses. This is done gently with the sucker. Occasionally a large fragment of bone plugs the missile tract, and after its removal necrotic brain, blood clots and small bone chips will gush forth. It is well to count the bone chips when removed, to check with the number seen at x-ray. The tract is cleaned down to the deepest bone fragment. As a rule, the metallic body is deeper. It is a question whether further debridement beneath the last bone fragment is necessary.

The ideal is closure of all layers. Frequently the dura cannot be closed. If closure is impossible, a free or a flap graft of the aponeurosis aponeurotica is the ideal. The exposure is seldom large enough to use the outer layer of the dura. Leonard Titrud used it to good advantage in one instance in which a craniotomy had been performed. Preserved and fresh fascia lata

grafts have been used. The frontalis muscle was used frequently in frontal tears, where it is extremely difficult to suture the dura, particularly on the inferior surface of the frontal lobe.

As a rule the scalp could be closed, although relaxing incisions and flaps were occasionally used.

The postoperative care of these patients presents nothing of special interest. As examples of penetrating wounds, I present two cases with slides.

Case 1.—This boy, W. I. A., was hit at 1230 hours by flak which entered the left parietal region and came to rest in the right temporal region. He was admitted to the hospital four hours later, at which time he was deeply comatose. Three hours after admission (seven hours after injury), the tract was debrided and the foreign body removed as you will note in the slide. Then he regained consciousness, he had light perception in the right eye, but no vision in the left eye. Five weeks later (after having meningitis), his vision gradually returned.

Case 2.—This case represents an important point, namely, that all penetrating wounds should be explored regardless how small they are. He was hit by flak at 1300 hours. He was knocked down and thought he was unconscious for a few seconds. He was rather drowsy when observed at a station hospital. Because the wounds seemed so small, they were cleaned superficially. Ten days later he was admitted to our hospital complaining of headaches, and with a choked disc. The point of entrance in the bone was only a few millimeters in diameter, but the defect in the dura was 2 cm. in diameter. As soon as the dura was retracted, about 10 c.c. of blood and necrotic brain gushed forth. The tract was gently debrided to a depth of four centimeters, and the wound closed. His recovery was uneventful and he was later returned to full duty.

There were all gradations of severity between these two types. Those treating ground force troops observed more severe wounds than were observed in the air force.

The early complications arising from penetrating wounds were herniation of the brain with resulting cerebral fungus, abscess, meningitis, rhinorrhea, and otorrhea. Fortunately, we had little experience with these sequlae, mainly due to the fact that our series was small. In thirty-two cases of penetrating wounds observed in Africa, three developed brain abscesses. In thirty-one cases of penetrating wounds in Italy, three developed meningitis and one a brain fungus. Only one of these seven died, a patient with a brain abscess.

A brain abscess developing from such a wound is different from those that develop from otologic or sinus infections, mainly in that there is an open tract already outside. As a rule, opening the dura and tract with subsequent washing of the abscess cavity with penicillin will effect a cure. Two of the three abscesses observed in Africa were enucleated in toto, one by Titrud and one by French. The other patient died twenty-two days after injury, after aspiration of the abscess and debridement of the fungus.

I do not have the statistics for the development of brain abscesses, but I do know that their incidence decreased a great deal as time progressed. The results of our two cases were excellent with their removal in toto, but good results were reported by aspiration and tube drainage of the abscess cavity with instillation of penicillin.

The development of a cerebral fungus was a dangerous complication. They were of two kinds, acute and chronic. The acute were usually due to an early edema, and receded without specific treatment. The chronic were more difficult to care for, but were usually due to some disturbance deeper within the brain substance such as an abscess around bone fragments or a hemorrhage. They would not disappear until the underlying disease had been eradicated. Fortunately, we had only two cases in our group. One died with an underlying abscess and the other receded by itself.

The low incidence of meningitis, three in sixty-five cases of penetrating wounds, was no doubt due to early debridement. Two of these were due to other factors, infected fibrin film and faulty technique in one, and cerebrospinal fluid drainage in the other. The third was due to a delay in debridement, seven days after wounding. It is interesting to note that all three individuals developed meningitis in spite of their having had adequate doses of penicillin. As has been stated, they were all treated with intrathecal penicillin and two recovered. The cause of their meningitis was eradicated at the same time, but it was our impression that penicillin did aid in their recovery.

Only one case of persistent rhinorrhea was observed. This was surprising, as there were many frontal depressed fractures caused by crash landings, in which the dura in the region of the crista galli was torn. In several instances fibrin foam was packed into the region. Flaps of frontalis muscle were particularly helpful in closure of these wounds. In the one persistent case, a fascial graft was used for covering the defect.

It was surprising to us that intracranial hemorrhage did not play a greater role in penetrating wounds. Shoreston stated that there were only eighty-three cases in 2,000 in which an intracranial hemorrhage played an important role. It was interesting to note in cases in which the missile passed through the brain hitting the skull on the opposite side, that the hemorrhage was frequently on that side, namely, the side opposite the entrance. The repair of cranial defects was not, as a rule, a procedure for overseas installations. However, it was found advisable to perform cranioplasties in several instances. Tantalum was not available. Free bone grafts were used from the ileum or from the outer table of the skull, as demonstrated by the following slides.

Naturally, and particularly at the outset, the main interest was the penetrating wounds of the brain. We did have, however, many closed wounds of the head and depressed fractures which present no special featues.

Only three brain tumors were operated upon during our service. A large astrocytoma was partially removed in one instance. A cerebellar medulloblastoma was removed in another. The third case was a large ependymoma of the lateral ventricle.

As in all services, unusual cases present themselves. The following case was interesting:

A thirty-one-year-old soldier, with two and one-half years of service, had been well until November 1, 1942, when he developed a headache and blurring of his vision, after a severe sandstorm near Benghasi, Lybia. He soon recovered, but had intermittent headaches for the next eleven months. In December, 1943, he had chills and fever, and he was told that he had malaria. At this time his headaches became severe. On admission to our hospital, there was a two diopter choke of both discs. There was a slight right 6th crania nerve paresis.

X-ray examinations is as demonstrated on the slides. On January 19, a right transfrontal craniotomy was performed and a large cyst was demonstrated beneath and lateral to the optic chiasm. The cyst was evacuated and subsequent microscopic inspections revealed a cysticercus cellulosa. His post-operative course was uneventful. Nine months later he was reexamined and found to have performed full duty and had no complaints.

It is impossible to discuss the posttraumatic state here. Suffice it to say, it was a great problem and the will to return to duty was a great factor in the ultimate well-being of the patient.

I am unable to give the full statistics of our head injuries but I do have the data extending from January to October, 1944, ten of the seventeen months of activity. Of the twenty-seven patients with penetrating wounds, eight returned to duty, fourteen were returned to the U. S., and three died. Of eighteen patients with depressed fractures thirteen returned to duty, five were sent to the U. S., and none died. Of 137 patients with closed wounds 102 returned to duty, seventeen to the U. S., and five died.

Of 180 cases of all types, 68 per cent returned to duty, 28 per cent were sent to the U. S., and 4.5 per cent died.

The mortality of our penetrating wounds was approximately 19 per cent.

Nerve Injuries

At a neurosurgical conference in Florence, it was stated that the most pressing problem presenting itself to the conference was that of injuries to the peripheral nerves. May I present to you our experience with these injuries.

Both in Africa and in Italy we observed 445 patients with peripheral nerve injuries. One hundred and nineteen of these cases were operated upon, there being thirty-nine nerve sutures.

Factors which included difficulty in evacuation and satisfactory control of infection prompted an early repair of severed nerves.

Seventy-five per cent of the nerve lesions were in the upper extremities and the ulnar nerve was most frequently involved.

Penetrating wounds caused 79 per cent of the lesions.

Forty-three per cent were judged to be complete lesions at the time of the initial examination.

The average time of beginning recovery in the complete lesions not operated upon was thirty-four days. The ulnar and median nerve recovery was somewhat less than this period and the radial, femoral, and tibial was slightly more.

As time went on the flexible rule was that if recovery or improvement did not take place in four weeks in the ulnar, median, and musculocutaneous, six weeks in the radial and seven to eight weeks in the peroneal nerves, they should be explored provided, of course, the wounds were in a satisfactory state.

Incomplete lesions were explored if they showed no improvement on an average of forty-three days after injury.

Operations.—One-hundred and fourteen operations were performed of which thirty-nine were sutures, two autogenous nerve grafts, and seventy-three neurolyses. As a general rule, the gross reaction from the original injury had disappeared by four weeks. The scar present was firm and not edematous. Cultures were negative. Microscopically, there were a few giant cells and lymphocytes present but no evidence of acute infection.

There was one postoperative infection. Fibrin film was used in some instances as a cuff but was discontinued due to a very apparent increase in late postoperative reaction.

Early Results and Disposition of Cases.—None of the nerve sutures revealed any functional return prior to disposition from this hospital.

In a number of instances in which neurolysis was performed there was a rapid return of sensation and motor power. This was not always true as in two cases there was definite subjective and objective evidence of improvement in the first three or four days and then a return of the original condition with no further improvement at the time of discharge.

There were thirty-one cases of painful nerve lesions. Seven of these were sensory nerves. Fourteen of the twenty-four motor nerves involved were the sciatic or tibial or peroneal nerves. They all complained of severe pain in the foot, except one in whom there was a burning pain down the leg. This was the only one whose pain was relieved spontaneously (thirty-one days). In the lower extremity, the pain involved for the most part the plantar aspect of the foot. In the majority of cases, in which the nerve was demonstrated at operation, the nerve had been definitely struck by the missile.

The usual time interval for the onset of the pain was ten to fourteen days. Frequently as motor and sensory power increased, pain occurred. Sympathetic block gave the best relief in two brachial plexus injuries. One was permanently cured by novocain block alone and the other by sympathectomy.

Ten patients were relieved temporarily by sympathetic block. Two were not relieved.

Seventeen neurolyses were performed. All of them were relieved of their severe pain.

Late Results.—Follow-up records were obtained in 53 per cent of all the cases, operated and unoperated. Adequate follow-ups were received from twenty of 74 per cent of those operated upon. The follow-up interval ranged from six months to one and one-half years.

Summary

In six months five showed partial return; in one year ten more showed partial return. If there was no return in one year no improvement could be expected. It

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did take one year before recovery took place in peroneal and radial nerve sutures. In fifty-two neurolyses, in six months, eighteen showed partial recovery and four no recovery. In one year twenty-eight more showed partial and two no recovery.

There was a definite relationship between preoperative interval and the number showing recovery in both nerve sutures and neurolyses. Ulnar and median nerves seem to recover fastest. Practically all patients in whom recovery took place experienced associated pains and hyperesthesias in the cutaneous nerve distribution. Paresthesia was not a prominent symptom.

Discussion

DR. WILLIAM PEYTON: I congratulate Doctor Ritchie on this very excellent summary of his experiences in the war.

We have had a little fibrin foam for experimental purposes and found it most useful in controlling bleeding from the pituitary fossa after removal of pituitary adenomata. Fibrin foam and thrombin placed in the operative defect and left there completely controlled all oozing of blood which is so essential for uneventful recovery in these cases. I regret very much that we no longer have any fibrin foam available for this purpose.

The difficulty seems to be that in peacetime there is not a constant and sufficient amount of human blood being processed for the preparation of this product. Whether or not it will be available for general use is uncertain, but at present, prospects for its availability, do not appear to be very favorable.

In speaking of repair of skull defects, Doctor Ritchie said he had used a bone graft of the outer table of the skull instead of the more generally used tantalum, which was not available to him. The outer table of the skull makes a very satisfactory closure of small defects. The objection that has usually been made to the use of the outer table of the skull does not obtain with the technique employed by Dr. Ritchie. It has been the custom to remove these grafts with an osteotome and hammer. This procedure is traumatic to the intracranial contents and therefore objectionable. Doctor Ritchie showed in the illustrations (but he did not stress it) that he removed these grafts by sawing off the outer table with a Gigli saw, so that this objectionable trauma is entirely avoided.

Of course, tantalum can be used. It is certainly the best material for repair of large cranial defects. We have used it. The plate can be cut and properly shaped at the operating room table, unless the contour of the defect is complicated, as is the case where the superciliary arch is to be reconstructed.

Doctor Peyton then showed some lantern slides of some cases of head injury.

The first case was that of an aviator who, on February 25, 1944, had a large piece of flak enter his right temporal region. It passed to the left and slightly downward so that on reaching the midline it passed through the sphenoid sinus, entered and lodged in the left cavernous sinus where it injured the left internal carotid artery. A carotid-cavernous fistula was thus produced on the left side. On regaining consciousness, six days after the injury, he heard a swishing noise in his head and this remained until the day before he was seen by Doctor Peyton (July, 1945) when it suddenly stopped and he developed a very severe headache. This bruit had been noted by all previous medical examiners and a diagnosis of carotid-cavernous fistula made.

On examination there was exophthalmos of the left eye and a left sixth cranial nerve paresis. There were some enlarged veins in the left sclera and the retinal veins were engorged. Visual acuity was normal. No bruit was audible. He was seen again one week later when there still was no bruit and no symptoms except some diplopia due to the sixth nerve paresis.

It is obvious that the day before this man was seen, or seventeen months after his injury, a spontaneous occlusion of the fistula had occurred by clot formation or thrombosis. The patient was reassured that a spontaneous cure had now occurred.

The symptoms, physical findings and pathologic changes in carotid-cavernous fistula were then discussed. Its treatment by ligation of the internal carotid artery in the neck or by packing the internal carotid artery with muscle strips, or by ligating the internal carotid in the neck and occluding it above the cavernous sinus with silver clips was illustrated by cases briefly reported.

DR. L. H. FOWLER: I cannot add anything to the scientific discussion because Doctor Ritchie has covered the subject so thoroughly. I do want you to know, though, that I appreciate his efforts and his work. You can tell from his presentation the fine work he has done for three and one-half years as Chief of the Section on Neurosurgery of the 26th General Hospital. He was not only most skillful and tireless in his work, but one of the most popular—if not the most popular—men in the outfit, always on the job, always co-operative, always a gentleman and a scholar.

CAPT. NATHAN PLIMPTON, M.C.: I treated some cases of liver injuries with fibrin foam and saw several others that were treated in the same way. It not only controlled the hemorrhage very effectively, but we felt that it also sealed off the bile ductules as the bile drainage in these cases was considerably less than what we experienced before fibrin foam was available. There is no question but that this was the best method we had for handling war wounds of the liver.

DR. WILLIAM PEYTON: There is a substance called gelatin sponge being made as a substitute for fibrin foam and bovine thrombin is suggested as a substitute for human thrombin. I do not know how satisfactory these will be.

ERNEST R. ANDERSON, M.D.
Recorder

OFFICE OF THE SURGEON GENERAL REPRESENTED AT GORGAS INSTITUTE MEETING

Major General Norman T. Kirk, Surgeon General of the Army, and Brigadier General James S. Simmons, Chief of Preventive Medicine Service, Office of The Surgeon General, both board members of the Gorgas Memorial Institute of Tropical and Preventive Medicine, recently participated in an election of three new directors to the Institute.

The three included: Spruille Braden, former ambassador to Argentina and now Assistant Secretary of State, Rear Admiral H. W. Smith, Chief of the Navy Research Division of the Bureau of Medicine and Surgery, and Colonel R. G. Prentiss, Jr., Chairman of the Army Medical Research and Development Board.

GENERAL SIMMONS GUEST OF HONOR AT DINNER

Brigadier General James S. Simmons, Chief of Preventive Medicine Service, Office of The Surgeon General, was the guest of honor at a dinner recently given by Colonel Richard P. Strong, Director of Tropical Medicine of the Army Medical School. The guests included some of the nation's leading scientists and military doctors.

In Memoriam

EARL MELVIN ANDERSON

Dr. Earl M. Anderson, Minneapolis, a Lieutenant in the Navy, died at the Naval Air Station in Glenview, Illinois, July 5, 1945, as a result of numerous injuries received in an airplane crash. He was twenty-eight years old.

Dr. Anderson graduated from the University of Minnesota Medical School in 1941 and interned at the Minneapolis General Hospital. He served a fellowship in surgery at the Mayo Foundation at Rochester, and was commissioned a Lieutenant (jg) in the medical corps of the U. S. Naval Reserve on March 3, 1942.

EDWARD THOMAS ANDERSON

Dr. Edward T. Anderson of Excelsior, Minnesota, passed away November 1, 1945, at the Veterans' Hospital in St. Cloud where he had been since 1939. He was seventy-six years old.

Dr. Anderson was born at Dubuque, Iowa, August 30, 1869. He graduated from the School of Medicine at Sioux City, Iowa, in 1895, and practiced in South Dakota before entering the service in World War I. He served three years, one of them overseas, and because of impaired health resulting from service, retired soon after his discharge and lived at Excelsior, Minnesota.

He was a member of the Excelsior Methodist Church and the Excelsior Masonic Lodge.

Dr. Anderson is survived by his wife, one daughter, Mrs. R. L. Ward of Staples, Minnesota, and one son, Dr. Arnold Anderson of Lexington, Kentucky.

FLOYD F. CLARK

Dr. Floyd F. Clark of Duluth, died suddenly November 15, 1945. He was born at Churubusco, Indiana, November 17, 1875, and obtained his medical degree at the University of Illinois in 1908. He interned at Chicago Hospital and began practice in Duluth thirty-six years ago.

Dr. Clark served as examiner for the State Boxing Commission for four years, was physician for the jail of St. Louis County for fourteen years and at times was deputy county coroner.

He was a member of the St. Louis County Medical Society, the Minnesota State and American Medical associations, Tonic Lodge A.F. and A.M. and the Order of the Mystic Shrine.

Surviving are two sons: Lt. Floyd Clark, Jr., of the Navy and Fred Clark of Houston, Texas.

F. V. LANGENDERFER

Dr. Francis V. Langenderfer was born in Ohio, December 30, 1884. He graduated from Loyola University Medical College, Chicago, in 1907.

He was commissioned a Lieutenant in the Army Medi-

cal Corps and served three years in that capacity in the Philippine Islands.

Upon his return to the United States he started practicing medicine in Knapp, Wisconsin, where he also met and married Anna Kvool. He moved to Saint Paul in 1913, and opened an office at Rice Street and University Avenue. In 1923, he moved to new offices across the street in the New Capitol Drug Building, where he practiced medicine and surgery until he became ill in February, 1943.

He was a member of the Ramsey County Medical Society, Minnesota State Medical Association and American Medical Association, and was on the staff of St. Joseph's and Bethesda Hospitals.

Dr. Langenderfer died November 26 at St. Joseph's Hospital where he had been since October 7, 1944.

VICTOR N. PETERSON

Dr. V. N. Peterson died at Bethesda Hospital, Saint Paul, on November 28, 1945, after an illness of several months. Funeral services were held in Saint Paul on December 3. Interment was at Cokato, Minnesota. He is survived by his mother, Mrs. Anna Peterson of Mankato, Minnesota, and one brother, Mr. Leonard C. Peterson of Miami, Florida.

Dr. Peterson was well known in Saint Paul, having practiced there for thirty-eight years. He was located at 885 Rice Street for 11 years and in the Lowry Medical Arts Building since 1918.

He was born in Cokato, Minnesota, on September 5, 1879, and was the eldest son of Andrew P. Peterson and Anna Peterson. He attended the Cokato High School and in 1902 received his B.A. degree from Gustavus Adolphus College at St. Peter, Minnesota. In 1906, he was graduated from the University of Minnesota with the degree of doctor of medicine. After graduation, he practiced for one year at Starbuck, Minnesota, before coming to Saint Paul.

For a number of years he was on the staffs of Bethesda and Miller Hospitals. He was a member of the Ramsey County Medical Society, the Minnesota State Medical Association and the American Medical Association. In 1925 he was admitted as a Fellow of the American College of Surgeons. He was also a member of the Saint Paul Surgical Society and served as its president in 1939.

Dr. Peterson was a Shriner and an active member of the Osman Temple Shrine of Saint Paul. He was a member of the Saint Paul Athletic Club, where he made his residence after the death of his wife.

He will long be remembered by his many friends for his cheerful nature, his kindness and his sincerity. He was greatly esteemed by his associates for his excellent judgment and professional skill. He was always willing to be of help to the younger men, and his influence will ever be felt by those whom he so generously assisted.

At this time the members of the Ramsey County Medical Society wish to express their sorrow at his passing and their appreciation of having had the opportunity to be associated with one of such high character and outstanding ability.

J. Lawrence Noble, M.D.

COMMUNICATION

Minnesota Medicine
Dear Sirs:

Some of my medical society friends might like to know what has happened to me.

I volunteered for the Army while I was at Pine City and was ordered to active duty on 26 Jan. 1943. Was sent to Carlisle Medical Field Service School and thence to Stark General Hospital at Charleston, S. C., where I was placed in the medical pool. While there I was a ward officer on medicine and also medical officer on several hospital trains evacuating patients from Stark. On 1 May, 1944, I was ordered to the 141st General Hospital which was then being trained at Kennedy General in Memphis. We worked at Kennedy while there and finally were alerted and debarked from Port of New York on 15 June 1944.

While overseas, we operated the 141st General in Wiltshire in Devizes, a small town about 35 miles East of Bristol. We had patients within two weeks after arriving so were lucky in not having to wait about. My duties were officer on medicine and I had charge of the Prisoner of War wards. I averaged about seventy active prisoner patients and had a very interesting experience. It certainly was varied from battle casualties to Weil's disease. Had a small series of peculiar types of edema with no evidence of protein deficiency or renal disease. These were the "war nephritis" cases described by German medical officers. Recovery was usually prompt but occasionally very prolonged though the patients were not very ill. I feel these were on a nutritional basis in spite of the fairly normal serum protein levels. We also had a large series of diphtheria in these prisoners. These were interesting for adult diphtheria at home was rare. All recovered. This experience was most interesting and valuable because of the great variety of conditions seen.

In December I was appointed chief of the Gastro-Enterology Section and had all the consultations in this field as well as proctoscopic examinations. This likewise was valuable training for there was ample work in a hospital of this size (we averaged 2000 beds). Duodenal ulcer and hepatitis were the most common organic states but functional disorders were by far the most common and a difficult problem in many cases to handle. One month of my overseas stay was spent in London where I worked at the main dispensary at U.K. base in the medical section. This was varied too but less interesting to me than ward work where you could follow the patient through his illness. Being in London was kept interesting, however, by the Germans and their V1 and V2 bombs. One narrow escape was enough for me.

When the war ended we were slated for Pacific duty because we had only been overseas 11 months at the time of V-E Day. Thus we were shipped out of England

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early in order to get back to the States for training. Our trip home in June was marvelous, 4½ days on the Queen Elizabeth, as compared to 11 days going over in slow convoy. We had our 30-day leave which I spent with my family in Rochester, then joined the 141st at Camp Crowder, Mo. From then on it was a matter of sweating it out. The war was soon over, yet we were still slated for Pacific duty and were most unhappy about it, feeling that we had done our share of work overseas. We completed our 6 weeks of training including setting up field hospitals under canvas, tropical disease control and even familiarization with hand grenades, rifle, and pistol. Finally, however, I was ordered to the 6th Service Command and left the 141st with which I had served so long.

My present job is Chief of the Gastro-Enterology Section here at Vaughan Hospital, at Hines, Illinois, where 6th Service sent me. It is a fine service with 102 active beds and is really busy. Work is varied but consists mostly of duodenal ulcer and hepatitis plus all the varieties of colitis. I find it most interesting especially as I do the proctoscopies for the hospital and see a great number of interesting conditions. I am fortunate in having an able Captain as an assistant so we can handle the work adequately. I feel I am fortunate in getting this service for I am doing the work I like, am plenty busy, and seeing much interesting medicine.

I have been fortunate throughout my Army Service in that I have done clinical medicine all the time and have not lost touch with it like so many have. I hope to be discharged early in the spring and take some more postgraduate work in Internal Medicine. That concludes my story and a long one it is.

Very truly yours,

GEORGE E. BROWN, JR., Capt., MC.

BERT SHEPARD ASSIGNED TO THE OFFICE OF THE SURGEON GENERAL

First Lieutenant Bert Shepard, who attracted nationwide attention last summer when he resumed his professional baseball career as pitcher for the Washington Senators three days after receiving his GI artificial leg from Walter Reed General Hospital, has re-entered the service at the request of The Surgeon General to aid in a program designed to help amputees get the greatest use from their prostheses.

In May, 1944, Lieutenant Shepard's P-38 was shot down over Germany. He suffered the loss of the lower part of his right leg, the operation being performed by German surgeons. After eight months in German hospitals and prison camps, he returned to the United States aboard the Gripsholm in February of this year.

Wearing a crude artificial leg fashioned from Red Cross materials by a fellow Canadian prisoner, Lieutenant Shepard was sent to Walter Reed General Hospital where he received a GI prosthesis. Within three days after his fitting, he was working out with the Washington Senators and later signed with them. He plays football and has been clocked in the 100-yard dash at 12.05 seconds. He is the wearer of the Distinguished Flying Cross, Air Medal with three clusters and the Purple Heart.—*News Notes,* No. 34, Office of Surgeon General.

Reports and Announcements

MEDICAL BROADCAST FOR JANUARY

The following radio schedule of talks on medical and dental subjects by William O'Brien, M.D., Director of Postgraduate Medical Education, University of Minnesota, is sponsored by the Minnesota State Medical Association, the Minnesota State Dental Association, the Minnesota Hospital Association and the University of Minnesota School of the Air.

Jan. 2—11:00 (KUOM)	Foods Undergo Many Changes in the Body
Jan. 3— 5.15 (WCCO)	Nature of Heart Disease
Jan. 5—11:30 (KUOM-KROC-KFAM)	Medicine in the News
Jan. 9—11:00 (KUOM)	The Blood Travels to All Parts of the Body
Jan. 10— 5:15 (WCCO)	Rheumatic Fever
Jan. 12—11:30 (KUOM-KROC-KFAM)	Medicine in the News
Jan. 16—11:00 (KUOM)	Waste Materials Are Removed from the Body
Jan. 17— 5:15 (WCCO)	High Blood Pressure
Jan. 19—11:30 (KUOM-KROC-KFAM)	Medicine in the News
Jan. 23—11:00 (KUOM)	Sunlight and Fresh Air Are Health Essentials
Jan. 24— 5:15 (WCCO)	Coronary Disease
Jan. 26—11:30 (KUOM-KROC-KFAM)	Medicine in the News
Jan. 28— 4:45 (WCCO)	Sore Mouth
Jan. 30—11:00 (KUOM)	Your Body Needs Regular Exercise
Jan. 31— 5:15 (WCCO)	Your Hospital in Peacetime

AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians will resume its annual meetings in 1946 and has now definitely chosen Philadelphia as the place of meeting, May 13-17, inclusive. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce.

The meeting will be conducted under the presidency of Dr. Ernest E. Irons, Chicago, Illinois, and the general chairmanship of Dr. George Morris Piersol, 3400 Spruce Street, Philadelphia, Pennsylvania.

CHICAGO MEDICAL SOCIETY

The tremendous success of the First Clinical Conference held two years ago served as a mandate to the Chicago Medical Society for the annual continuation of this type of program. Last year the Conference was called off because of government restrictions on travel. This year the Society has been able to go ahead with its plans and the Conference will be held at the Palmer House, Chicago, Illinois, on March 5, 6, 7, and 8, 1946.

There will be scientific programs consisting of half-hour lectures beginning at 8:30 A.M. and continuing until 5:00 P.M. with intermissions for viewing the scientific and technical exhibits which promise to be most outstanding.

Speakers have been secured from all sections of the United States and the program committee promises a discussion of the important fields of medicine.

A banquet is being planned for Thursday night when a speaker of international reputation will talk on a topic of general interest.

Reservations for rooms should be made through The Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois. It is important that those planning to attend this Conference make their reservations as soon as possible and arrange to room with a friend. Hotel rooms are at a premium. Early planning and reservation will prevent disappointment.

MINNESOTA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

The first meeting for the 1945-1946 season of the Minnesota Academy of Ophthalmology and Otolaryngology was held at the Minneapolis Club on Friday, November 9, 1945.

The following men took office: Dr. K. C. Wold, Saint Paul, president; Dr. Theodore R. Fritsche, New Ulm, first vice president; Dr. C. L. Oppegaard, Crookston, second vice president; Dr. William A. Kennedy, Saint Paul, secretary-treasurer; Dr. Malcolm C. Pfunder, Minneapolis, chairman of Council.

The retiring president is Dr. A. G. Athens of Duluth.

Two papers were presented: "Air Restoration of the Anterior Chamber" by Dr. Frank Burch of Saint Paul, and "Facial Nerve Injury in Relation to Skull Fracture" by Dr. Jerome Hilger of Saint Paul.

RAMSEY COUNTY MEDICAL SOCIETY

Results of the Ramsey County Medical Association election of officers, conducted by mail, were announced at the annual meeting held on November 27 at Ancker Hospital, St. Paul. Dr. Harry B. Zimmermann succeeds Dr. Justus O'Hage as president; Dr. John M. Culligan is president-elect for 1947; Dr. John R. Aurelius is vice president, and Dr. Clayton K. Williams is secretary-treasurer.

ST. LOUIS COUNTY MEDICAL SOCIETY

The annual dinner meeting of the St. Louis County Medical Society was held on December 12 at the Northland Country Club, and election of the following officers was announced: President, Dr. P. G. Boman, Duluth, who succeeds Dr. William J. Ryan, also of Duluth; vice president, Dr. Francis W. Backnik, Hibbing; secretary-treasurer, Dr. Elizabeth C. Bagley, Duluth, succeeding Dr. Robert P. Buckley, Duluth.

The guest speaker was Walter T. Ridder, foreign correspondent for the Duluth *Herald and News-Tribune*, who presented a graphic picture of the "destitution and pauperism of the European peoples."

More than 160 physicians and their wives were present.

WOMAN'S AUXILIARY

MRS. EDWARD V. GOLTZ, *President*
Saint Paul, Minnesota
MRS. JOHN K. BUTLER, *Editor*
Carlton, Minnesota

STATE BOARD

Mrs. E. V. Goltz presided at the November meeting of the State Board at the Minnesota Club in Saint Paul. A large group of members was present and gave interesting reports of their organizations. The group was urged by Mrs. Harlow J. Hanson to encourage nurses to enter training. Although candidates are no longer accepted for Cadet Nurses, she reminded the group that the hospitals have their own courses and are happy to have applicants.

At the luncheon Dr. Wallace P. Ritchie talked on his experiences with the 26th General Hospital. Dr. Ritchie's mother, Mrs. Harry P. Ritchie, who has long been active in the Ramsey County Auxiliary and is a former state president, was also present.

* * *

BLUE EARTH COUNTY

The Blue Earth County Auxiliary met at the Mankato Clinic to elect officers and make plans for the year. Mrs. George Penn was elected president; Mrs. E. A. Sohmer, vice president; Mrs. Roger Hassett, secretary, and Mrs. P. G. Hoeper, treasurer. Committee chairmen appointed were *Hygeia*—Mrs. W. B. Kaufman; *Legislation*, Mrs. Roy Andrews; *Health Education and Public Relation*, Mrs. M. I. Howard, Mrs. O. H. Jones and Mrs. P. G. Hoeper; *Cancer Control*, Mrs. A. F. Kemp, Mrs. W. B. Kaufman, Mrs. M. I. Howard and Mrs. P. G. Hoeper. The doctors joined the ladies for a social evening after the meeting.

* * *

GOODHUE COUNTY

Mrs. R. F. Hedin was hostess at the November meeting of the Goodhue County Auxiliary. Because of the small membership it was decided to meet less frequently. However, members are keeping up their good work in making dressings for the Cancer Home in Saint Paul.

* * *

HENNEPIN COUNTY

Mrs. Erling Platou and Mrs. James Johnson were hostesses at the November meeting in the Medical Arts Building Lounge. Two members of the Auxiliary gave a musical program—Mrs. Richard Giere accompanied Mrs. A. S. Hoiland, who sang a vocal solo. Mr. Francis Harjashi, Professor of Japanese at the University of Minnesota, talked on "Out and Moved."

Auxiliary members staffed a booth at Dayton's at which they sold articles made by the Glen Lake Sanatorium patients, November 8 and 9. They netted over $3,000 from the sales.

KANDIYOHI-SWIFT-MEEKER COUNTIES

Mrs. S. B. Lindley entertained the Auxiliary at the Willmar State Hospital in November. Members heard an interesting talk on "Tuberculosis in the Army" at a joint meeting of the Medical Society and the Auxiliary. Afterwards both groups played bridge.

* * *

MOWER COUNTY

Members of the Mower County Auxiliary met at the home of Mrs. B. K. Cromwell and made cancer dressings.

* * *

OLMSTED-HOUSTON-FILLMORE-DODGE COUNTIES

Mayo Foundation House was the meeting place of the Auxiliary last month. Members heard Evelyn Beyer, director of pre-school activities of the child health project, talk on nursery schools.

* * *

PARK REGION

Nineteen members of the Northern Minnesota Auxiliary were guests of the Park Region Auxiliary at Fergus Falls, November 3, when the Park Region Auxiliary observed the twenty-fifth anniversary of its organization at Fergus Falls in 1920. Luncheon was served at River Inn Hotel. Later, Mrs. A. C. Baker entertained at tea. Mrs. J. L. Morrill and Mrs. E. V. Goltz were guests of honor. Mrs. Goltz urged the members to become more active in civic and medical organizations.

One hundred twenty-five members and guests attended the banquet at the State Hospital in the evening. The hospital orchestra furnished dinner music. Dr. W. A. O'Brien, toastmaster, introduced Dr. Richard Bardon, president of the St. Louis County Medical Society, and Dr. J. L. Morrill, president of the University of Minnesota, as speakers of the evening.

* * *

ST. LOUIS COUNTY

New members of the Auxiliary and wives of the interns from St. Mary's and St. Luke's Hospitals were guests at a luncheon at the Hostess House. After a short business meeting, the women played bingo, using as prizes white elephants donated by the members. The proceeds, $14.85, will be added to the philanthropic fund. This amount combined with the proceeds for the rummage sale netted over $200 this year.

* * *

STEARNS-BENTON COUNTIES

Mrs. Wm. Friesleben of Sioux Rapids entertained her group at a pot luck supper in November. Mrs. T. N. Fleming, public relations chairman, reported on the progress of the tuberculosis contest, for which the Auxiliary gives a $5.00 prize.

* * *

WASHINGTON COUNTY

Eight members and two guests met at the home of Mrs. D. Kalinoff in Stillwater for the November meeting of the Washington County Auxiliary.

Of General Interest

Peter A. Arling, Minneapolis, has recently been made a Lieutenant Commander and is stationed on Guam.

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Dr. William E. Hart has opened a hospital in Monticello.

* * *

Dr. Thomas E. Havel has returned from military service to his practice at Blue Earth.

* * *

Lieutenant Colonel George S. Bergh, who served with the U. S. Base Hospital 26 in North Africa and Italy, has returned to Minneapolis.

* * *

Lieutenant Commander Al N. Bessesen, Jr., Minneapolis, is serving in a large Naval Hospital on Samar Island in the Philippines.

* * *

Dr. Garnett B. Belote and Dr. Neil T. Norris have established a partnership for the practice of medicine in Caledonia.

* * *

Dr. David Anderson, Austin, has been discharged from military service and has resumed his practice at the Austin Clinic.

* * *

Dr. Oliver E. Sarff opened an office December 1, 1945, at 801 LaSalle Medical Building, Minneapolis, for the practice of urology.

* * *

Dr. John E. Minkler, until his recent discharge a captain and squadron surgeon in the Army Air Corps in Italy, is now in practice with the Duluth Clinic.

* * *

Dr. H. R. Tregilgas, of South Saint Paul, has been notified of his election to a fellowship in the American College of Surgeons.

* * *

Dr. John J. Ederer, formerly of Mahnomen, Minnesota, has opened offices at 4217 West 42nd Street, Minneapolis. He will engage in general practice.

* * *

Major Douglas P. Head has resumed practice at 1731 Medical Arts Building, Minneapolis. While in service he was the recipient of the Bronze Star.

* * *

Lieutenant Harry Brown, former Superintendent of Northwestern Hospital, Minneapolis, has been appointed Acting Director of Hospital Services for the Veterans Administration.

* * *

Dr. Paul F. Dwan, Minneapolis, announces that effective January 1, 1946, he is limiting his practice to rheumatic fever and diseases of the heart and circulation in infancy and childhood.

* * *

Dr. Carl J. Potthoff, Associate Professor of Public Health at the University of Minnesota, has been appointed Assistant Medical Director of the Red Cross with headquarters at Washington, D. C.

* * *

The Mayo Clinic has announced the appointment of Dr. R. J. Campbell, formerly of Bellevue, Iowa, as First Assistant Neurologist at the Clinic. Dr. Campbell recently returned from foreign military service.

* * *

Lieutenant Colonel Edward T. Evans has resumed practice at 1251 Medical Arts Building, Minneapolis. He served as chief of orthopedics in General Hospital 26 and later at Benjamin Harrison Hospital.

Dr. J. Emery Frank has re-opened his offices in Marshall after three and a half years in the Army. With rank of captain, Dr. Frank served as flight surgeon with an air force unit in England and France.

* * *

Dr. Abraham B. Rosenfield, who recently returned to his practice in Hibbing from four years in the Navy Medical Corps, has been reappointed school physician for District No. 27.

* * *

Dr. H. Robert Ransom, formerly of Staples, has opened offices for practice in Crosby and Ironton, since his recent discharge from the Army Medical Corps. He will make his home in Crosby.

* * *

Dr. A. J. Hagen of Moorhead was a delegate to the U. S. Chapter of the International College of Surgeons which convened in Washington, D. C., December 6, 7 and 8, 1945.

* * *

Dr. W. W. Will, a former president of the Minnesota State Medical Association, was elected a Fellow of the International College of Surgeons at the annual convocation at Washington, D. C., December 7, 1945.

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Dr. William R. Blomberg has purchased the building which he has been occupying in Princeton and will begin extensive remodeling as soon as the weather permits.

* * *

Captain Gilbert P. Wenzel, Saint Paul, who has been stationed in the Central Pacific for the past eight months, was recently transferred from Guam to Okinawa.

* * *

Major Louis Sperling, Minneapolis, has located in Beverly Hills, California. He is associated with Mark Rabwin in the practice of surgery at 9730 Wilshire Boulevard.

* * *

Major Harold J. Black has returned to Saint Paul following his discharge from service. He was Commanding Officer of the 53rd Field Hospital in the active service in Normandy, Belgium and Germany.

(Continued on Page 86)

(Continued from Page 84)

Dr. Harold Hans Noran, formerly of Washington, has opened offices at 507 Physicians and Surgeons Building, Minneapolis. He will limit his practice to Neurology and Psychiatry.

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Dr. Maurice L. Straus, who has returned from service, will reopen his office at 726 White Bear Avenue, Saint Paul, on February 1. Dr. Straus served as captain in the Medical Corps with the 41st Infantry in northern Australia and in New Guinea.

* * *

Dr. Willis L. Herbert, captain in Army Medical Corps, entered service in March, 1944. He served in blood donor centers in Detroit and Minneapolis, and the separation center at Camp McCoy. He has resumed general practice with offices at 307 Hennepin Avenue.

* * *

Dr. Victor K. Funk, commander, entered service in April, 1942, and served as senior medical officer aboard the *USS Orion* in the Pacific for seventeen months. Dr. Funk has rejoined the staff at Glen Lake Sanatorium.

* * *

Dr. Henry W. Woltman was elected staff president and Dr. John Berkman was re-elected secretary of the Mayo Clinic staff at the annual meeting held at the Foundation House. Dr. John de Jarnette Pemberton is the retiring president.

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The marriage of Dr. James Peter Murphy to Lieutenant Barbara E. Fuller, Army nurse, took place at the post chapel at Langley Field, Hampton, Virginia. Dr. Murphy is the son of Dr. and Mrs. Francis E. Murphy, of Minneapolis.

* * *

Dr. George Olds, who was associated with Dr. Bernard Gallagher in the practice of medicine at Waseca at the time of his induction into military service, has opened offices in New Richland. Dr. Olds served as a captain in the Army Medical Corps.

* * *

Dr. Rolf M. Iverson, formerly of Pasadena, has become associated with Dr. Robert G. Allison in the practice of radiology. He served a Fellowship in the Graduate School of the University of Minnesota at Rochester before coming to Minneapolis.

* * *

At a meeting of the Range Medical Society held in Virginia, Minnesota, on December 18, 1945, the following officers were elected for the year, 1946: President, Dr. R. A. Salter, Virginia; Vice President, Dr. F. R. Kotchevar, Eveleth; Secretary, Dr. David A. Sher, Virginia.

* * *

Dr. Nathan C. Plimpton, Jr., has been discharged from the Medical Corps of the Army and is associated with Dr. O. J. Campbell, 1251 Medical Arts Building, Minneapolis, in the practice of surgery. Dr. Plimpton was a Fellow in the Graduate School of the University of Minnesota at Rochester before enlistment.

* * *

While on a hunting trip near Cayuga, North Dakota, Dr. Frederick A. Thysell, of Moorhead, slipped as he got out of his car and fractured a vertebra. Dr. Thysell was taken by ambulance to St. Angar's Hospital in Fargo, where he was expected to have to remain for some weeks.

* * *

Dr. Einer M. Monson, captain in the Army, entered the service in November, 1942, and was on Surgical Service with the 327th Station Hospital in England and France for sixteen months. He has returned to general practice with offices at 4144 Fremont Avenue North.

* * *

Dr. Karl Sandt, major, entered service in February, 1942, and went overseas in October, 1942. He was Chief of Eye Service for General Hospital 26 in England North Africa and Italy. He has returned to his practice of ophthalmology in his offices in the Medical Arts Building.

* * *

Dr. Walter Alvarez, Mayo Clinic, was guest lecturer for the Autumn Postgraduate Course of Queen's University Medical Faculty in Kingston, Ontario. Dr. Alvarez' subjects were "Diagnostic Hints for General Practitioners", and the "Diagnosis of Puzzling Types of Pain."

* * *

Dr. William J. Noonan, lieutenant colonel, entered service in May, 1941, and served as Chief of the Urology Department at Camp Gruber, Oklahoma, and Glennan General Hospital, Okmulgee, Oklahoma. He has resumed his practice of urology in temporary offices in the Medical Arts Building.

* * *

Dr. Paul W. Kebler, major, entered service in April, 1942, and was sent as Laboratory Officer for General Hospital 26 in England, North Africa, and Italy. He has returned to his position as Chief of Laboratories of the Division of Preventable Diseases at the University of Minnesota.

* * *

Dr. Robert E. Johnson, major, entered service in February, 1942, and went overseas in October as war surgeon with General Hospital 26 in North Africa and Italy. Later he was commanding officer of the Adriatic Base Command General Hospital. He has returned to general practice, with offices in the Medical Arts Building.

* * *

The War Department has announced the promotion of Dr. Edward Dyer Anderson, of Minneapolis, to the rank of captain in the Navy Medical Corps.

Captain Anderson is now serving as Chief Medical Officer at the Marine Base on Parris Island, North Carolina, after twenty-one months of duty aboard a hospital ship.

* * *

After three years in the armed forces, Dr. Russel Carlson has returned to his practice in association with Dr. Francis M. McCarten in Stillwater. Dr. Carlson had been with Dr. McCarten for a year and a half when he was inducted into military service, where he was a captain with twenty-one months' duty in the European Theatre.

Dr. Dean K. Rizer, major, entered service in November, 1942. He went overseas in July, 1944, and served as Chief of the Medical Section of the 119th General Hospital in England, and the 220th General Hospital in France. He has returned to his practice of internal medicine with offices in the Medical Arts Building.

* * *

After three years as commander in the Navy, Dr. Chester J. Olson has returned to his offices at Belle Plaine. Dr. Olson's service included duty at Camp Farragut, Idaho, Columbia University, Okinawa, and the Naval Training Base at Great Lakes, where for the past four months he has been engaged in discharge examinations.

* * *

Dr. John R. Paine, lieutenant colonel, entered service in February, 1942, and went overseas in October of the same year. He was Assistant Chief of Surgical Service with General Hospital 26 in England, North Africa and Italy. Dr. Paine has returned to his position of Associate Professor in Surgery at the University of Minnesota.

* * *

Dr. Reinhold M. Ericson, major, in service from July, 1943, was sent overseas in November, 1944, and attached to the 116th Evacuation Hospital at Sarreburg, France, and later, after the Rhine crossing, near Munich and at the Dachau concentration camp. An eye, ear, nose and throat specialist, his offices are in the Physicians and Surgeons Building.

* * *

Dr. Rudolph E. Hultkrans, captain, in Army, entered service in August, 1943; was twenty-two months as chief of orthopedics at the 103rd Evacuation Hospital from the Normandy landing and through France into Germany. Was later assigned to the 48th General Hospital in Marseilles, France. Has returned to his offices in the Medical Arts Building for the practice of surgery.

* * *

Dr. Lester Fogner, who was practicing in association with Dr. Wallace R. Smith at Grand Marais prior to his induction into the armed forces, has been appointed on the staff of the Veterans' Hospital in Minneapolis.

While he was in service Dr. Fogner, a major in the 28th Infantry, was taken prisoner by the Germans on December 17, 1944. He was liberated the following May.

* * *

Dr. Warner Ogden has resumed practice at his former office, 714 Lowry Medical Arts Building, Saint Paul, following his discharge from the Navy. Stationed first at the Naval Hospital on Treasure Island, San Francisco, Commander Ogden spent twenty-one months at a Shore Base in the Northern Solomons with Naval Aviation, and since June, 1945, has been assigned to the Naval Hospital at Corvallis, Oregon.

* * *

At the annual clinical meeting of the Ramsey County Medical Society held at Ancker Hospital, November 29, 1945, the staff voted to name the annual meeting the Arnold Schwyzer Clinical Meeting of the Ramsey County Medical Society in memory of the late Dr. Schwyzer,

who for many years was one of the outstanding Clinicians of Saint Paul, and the originator of the annual clinical meeting of the society.

* * *

Dr. Donald McCarthy, captain in the Navy, entered service in September, 1940. He was in Naval Medical Corps recruitment work for fifteen months and was then made Chief of Medicine on the H.S. *Relief,* with duty in both Atlantic and Pacific Theatres for the following two years. Subsequently he was Chief of Medicine at the Naval Hospital at Great Lakes, Illinois, and then Senior Medical Officer on Midway Island. He has resumed his practice of internal medicine with offices in the Medical Arts Building.

* * *

Dr. William T. Walsh, captain, entered service in February, 1942, and went overseas in October, 1943, as flight surgeon for the 312th Bombardment Group. He wears six battle stars, a Unit Citation and the Philippine Liberation Ribbon and Star, earned in service in Australia, New Guinea, the Philippines and Okinawa. He has returned to general practice with offices in the La Salle Building.

* * *

Dr. Oscar Lipschultz, lieutenant colonel, entered service in March, 1942, and went to North Africa and Italy in October of the same year as Chief of X-ray Service for General Hospital 26. Later he was assigned to the 45th General Hospital in Italy. Dr. Lipschultz has resumed his practice in his offices in the Medical Arts Building and has also returned to his position as Director of X-ray Department of the General Hospital.

* * *

Dr. Paul Swedenburg, formerly of Swanville, has entered medical practice at Little Falls, where he will share offices with Dr. Douglas L. Johnson and Dr. Roman V. Fait.

A graduate of the University of Minnesota Medical School, 1931, Dr. Swedenburg was associated with Dr. Edwin J. Simons in Swanville when he was inducted into service five years ago.

* * *

Dr. W. McK. Craig, formerly neuro-surgeon of the Mayo Clinic who is at present chief of the Bethesda Naval Hospital, Maryland, was one of four distinguished surgeons elected to honorary fellowship in the International College of Surgeons at Washington, D.C., on December 6. Dr. Craig is the only physician in American history ever to be given the rank of Rear Admiral He was the principal speaker at the annual banquet, his subject being "Surgery in the Navy."

* * *

Dr. R. B. Graves, while in Red Wing on terminal leave, purchased a building where he expects to occupy offices some time in January. Before entering military service in 1942, Dr. Graves was a member of the Medical Block Clinic in Red Wing.

In seventeen months of overseas duty as Flight Surgeon of a heavy bomber squadron, Dr. Graves earned the ETO ribbon with six battle stars and flight surgeon's wings.

* * *

Dr. W. S. Broker, who has been in tuberculosis sanatorium work for the past twenty-four years, has resigned his position as superintendent of Fair Oaks Lodge Sanatorium at Wadena to accept an appointment as superintendent of Pleasant View Sanatorium, East St. Louis, Illinois. He succeeds Dr. Robinson Bosworth, who was formerly executive secretary of the Minnesota Sanatorium Commission. Dr. Bosworth intends to enter private practice in Rockford, Illinois.

* * *

Dr. I. E. Bigler, a 1938 graduate of the University of Minnesota School of Medicine, who has been in military service since 1941, has opened offices in Crosby and bought a home there. Prior to his induction into the armed forces, he had been practicing at Ada, Oklahoma, for two years. Dr. Bigler was a flight surgeon with the Air Transport Command in the European Theater of Operations and also served with an Arctic Search and Rescue Squadron in Labrador for a year.

* * *

After two years in the Pacific Theatre, Dr. John E. Westrup has been discharged from service and is again in practice in Lanesboro, where he had been located for three years prior to his induction into the Navy. As lieutenant commander, Dr. Westrup served at Saipan, Attu and Tarawa. Later he was assigned to the Office of Procurement in Chicago, and recently he was at the Separation Center at Great Lakes Naval Station.

* * *

The lectures given at the December session of the Annual Industrial Safety School in Duluth included the following: "Digestive Disturbances." by Dr. Philip F. Eckman; "Industrial Dermatoses," by Dr. Merriam G. Fredericks; "Respiratory Hazards in Industry," by Dr. G. Arvid Hedberg; "Heart Disease," by Dr. Frank J. Hirschboeck; "Sprains and Strains," by Dr. S. Sverre Houkom; and "Sickness Can Be Prevented," by Mario Fischer, city director of public health.

* * *

Dr. Andrew V. Grinley, formerly of Rockwell City, Iowa, is now associated in practice with Drs. Francis and Raymond Jolin and Maurice McKenna at Grand Rapids.

Dr. Grinley graduated from Rush Medical College in Chicago and interned at Ancker Hospital in Saint Paul, where he was also resident physician. He was in military service from May, 1942, until his recent discharge, and served in the ETO for thirty-nine months.

* * *

Mr. M. Albert Linton, chairman of the Life Insurance Medical Fund, has announced that grants totaling $126,000 to be used this year for research into the cause of cardiovascular disease have been made to Columbia, Yale, Washington (St. Louis), Minnesota and Pennsylvania Universities, and to Southwestern Medical College at Dallas, Texas. Dr. Maurice Visscher of the Department of Physiology and Dr. Arthur Kirschbaum of the Department of Anatomy will supervise the expenditure of research funds at the University of Minnesota.

* * *

Dr. Harry B. Neel returned to his practice of surgery in the Albert Lea Medical and Surgical Center in November, after three years service in the Navy. In addition to duty at several naval hospitals in the United

States and Hawaii, Dr. Neel served aboard the H. S. *Solace* during the campaigns of the Marshall and Palau Islands, and the Mariannas.

Since his return from overseas duty a year ago, Dr. Neel had special training in x-ray diagnosis and was in the x-ray division at the U. S. Naval Hospital in Norman, Oklahoma, until his recent discharge.

* * *

After twenty-five years of medical practice in association with his brother, Dr. Berton J. Branton, at the Willmar Clinic, Dr. Aloys F. Branton has left Willmar for Chattanooga, Tennesse, where he will be superintendent of the Baroness Erlanger Hospital, an institution of 700 beds.

Dr. Branton is a graduate of the University of Minnesota Medical School, Class of 1920. He served as president of the Minnesota Hospital Association for several terms and had been executive secretary for the past eight years.

* * *

After an absence of five years in the Army Medical Corps, Dr. N. J. Kulzer has returned to his practice of medicine and surgery in Hastings. With rank of captain, Dr. Kulzer was on overseas duty for sixteen months. In January, 1943, he was transferred to the O'Reilly General Hospital, Springfield, Missouri, orthopedic and plastic service. In April, 1945, he was sent to Carson General Hospital, Colorado Springs, for surgical service and remained there until discharged in November.

Dr. W. E. Parker, who has been associated with the Davis Clinic at Wadena, since his honorable discharge from the U. S. Army in August, 1945, has located in Sebeka.

Dr. Parker graduated from the medical department of the University of Minnesota in 1934 and served two years interneship in Oklahoma City, Oklahoma. He then practiced medicine at Davis, Oklahoma, for six years, until he entered the service in May, 1942.

* * *

Dr. Clayton E. J. Nelson, recently discharged from the Army Medical Corps after three years of service, is now practicing at the Gamble Clinic in Albert Lea.

Dr. Nelson is a graduate of the University of Minnesota Medical School, and served his internship at Bethesda Hospital, St. Paul, and Augustana Hospital, Chicago. While in service he was on the staff of the 79th General Hospital, which was located successively at Belfast, Ireland, Southhampton, England, and north of Rheims, France, where he specialized in orthopedics.

* * *

A fire, which is believed to have originated in a defective heating plant, completely destroyed the office of Dr. William G. Rogne's at Spring Grove, while the doctor was in El Paso, Texas, awaiting his discharge from military service. When the blaze was finally extinquished, all that remained of the fine structure which Dr. Rogne had completed in 1941 were the outside walls. During his absence, Dr. Rogne had stored his equipment in the building and some of it was saved. Both

building and equipment were fully covered by insurance.

* * *

Dr. Marland R. Williams, Cannon Falls, has announced that hereafter he will be associated in practice with Dr. Ralph H. Larson, who was recently released from military service.

Dr. Larson graduated from the University of Minnesota Medical School in 1940 and entered the Army Medical Corps the following year. He was on duty in military hospitals in this country until 1943, when he was sent to the European Theatre as battalion surgeon with an infantry division. Wounded, he was evacuated to England and after his recovery was attached to a general hospital there.

* * *

Dr. Victor J. Bruder has resigned as radiologist at the Winona General Hospital and the Winona Clinic and hereafter will be associated with the Gunderson Clinic in La Crosse, Wisconsin.

A native of London, England, Dr. Bruder received both his Bachelor of Science and medical degrees from Loyola University in Chicago. Following the completion of his internship at the Waterbury Hospital in Waterbury, Connecticut, he specialized in x-ray diagnosis and treatment and radium therapy at Johns Hopkins Hospital in Baltimore. He was also instructor in Radiology at Johns Hopkins University. He has been certified as a specialist by the American Board of Radiology, and is a member of the National Board of Medical Examiners.

* * *

Dr. Alvin M. Nielson, recently discharged from the Navy after three years of service, has returned to his practice in Northfield.

Following a course in jungle training on Samoa, Dr. Nielson, with rank of lieutenant, served with the Second Marine Division in New Zealand and participated in the campaigns of Tarawa, Saipan and Tinian. He was awarded the Legion of Merit—one of the highest Navy decorations—a Presidential Citation, and the Purple Heart.

Dr. Nielson graduated from the University of Minnesota Medical School and served his internship at St. Joseph's Hospital in Saint Paul. He had been in practice in Northfield for two years when he was called into service.

* * *

Dr. Robert Otto Meyer, whose books and articles—numbering about 350—are standard works in medical libraries, was admitted to American citizenship in the Minneapolis Federal Court in December.

Dr. Meyer, honorary professor of gynecological pathology at the University of Berlin, fled with his wife from Germany when war was declared in 1939. He was enabled to come to America where the University of Minnesota made him a clinical associate without pay. Since then his expenses have been paid by American physicians who were his former students, with some assistance from the Jewish Refugee Fund. Dr. Meyer is now engaged in private teaching.

Dr. John McKelvey, head of the Department of Obstetrics and Gynecology at the University, is one of a number of American physicians who were privileged to study under Dr. Meyer in Berlin.

Mrs. Meyer died in this country in 1940.

* * *

Announcement has been made by Dr. Harry N. Sutherland, of Shipman Hospital at Ely, of the appointment of Major John D. Barker to the hospital staff.

Dr. Barker, a member of the Army Medical Reserve Corps, was practicing at Warren when he was called to active duty in July, 1941. As a first lieutenant, he served at a station hospital at the Portland Army Base until January, 1943, when he was ordered to the aviation school at Randolph Field, Texas, for study. On completion of his work he was returned to the West Coast where he served as flight surgeon with various groups until November, 1943, when he was sent overseas. He returned from Munich last fall wearing two Presidential Unit Citation ribbons, the Bronze Star Medal and six battle stars.

A native of Hibbing, Dr. Barker graduated from the University of Minnesota School of Medicine in 1939 and completed his internship at St. Mary's Hospital in Duluth in 1940.

* * *

Drs. Arnold O. Swenson, Karl E. Johnson, Daniel W. Wheeler and Gordon C. MeRae, all of Duluth, have been discharged from military service and are again in practice.

Dr. Swenson — commander — was in service for four and a half years and stationed at Naval hospitals in Bremerton, Washington, Portsmouth, Virginia, and San Francisco. He served as Chief of Surgery in a fleet hospital in New Guinea and Senior Medical Officer at a Navy base in Manila.

Dr. Johnson — Commander — served four and a half years as Senior Medical Officer and Chief of Surgery in this country, Hawaii, Midway Islands, Kwajalein, Guam and Majuro. He wears the Purple Heart for wounds received on Guadalcanal, and for his surgical work was honored with a special letter of commendation and a Presidential Unit Citation.

Dr. MacRae — lieutenant colonel — entered service in 1942. He was Commanding Officer of the 34th Station Hospital in England for two years, and later held the same office in the 53rd General Hospital.

Dr. Wheeler — captain — enlisted in the Navy immediately after Pearl Harbor. He was stationed at a Naval Base Hospital in Bremerton, Washington, and later was Executive Officer of a Corps Evacuation Hospital on Okinawa.

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The Hennepin County Medical Society has announced the return from military service of the following physicians:

Dr. Charles A. Aling, major, assigned to 100th Evacuation Hospital in France and Germany, has returned to his offices at 2300 Central Avenue, Minneapolis.

Dr. Samuel G. Balkin, major, attached to evacuation hospital throughout entire Italian campaign has returned to offices in the Medical Arts Building.

Dr. Reuben Berman, major, entered service in August, 1941, and served as flight surgeon in the Eighth Air Force in England, and was later on a medical intelligence team with the Ninth Air Force in France,

Germany and Austria. He was awarded the Bronze Star Medal. Dr. Berman has resumed practice of internal medicine in temporary offices in the Medical Arts Building.

Dr. Harvey Brekke, captain in the Army, entered service in June, 1942, sent overseas in November, 1943, assigned as medical and surgery officer with the Eighth Convalescent Hospital in England, France, Holland and Germany. Dr. Brekke has returned to his offices in the LaSalle Building, where he is associated with Dr. Iver Sivertson.

Dr. Carl G. Casper, major, entered service in April, 1941, went to South Pacific in March, 1942, where he served throughout entire New Guinea campaign as orthopedist with the Tenth Evacuation Hospital and the 363rd Station Hospital. Returned to this country, he was assigned to the Mayo General Hospital in Galesburg, Illinois. He has resumed practice of orthopedics in Medical Arts Building.

Dr. Ray F. Cochran, lieutenant-commander, entered service in October, 1942, was attached to Milne Bay Hospital and participated in five landings; later at the Naval Hospital in San Diego, California. He has resumed his practice of obstetrics, with offices at 1009 Nicollet Avenue.

Dr. Reuben F. Erickson, lieutenant colonel, entered service in February, 1942, and served as executive officer of the Twenty-sixth General Hospital in North Africa and Italy. He returned to this country and was executive officer at the convalescent hospital at Camp Butner, North Carolina. He has resumed his practice of gynecology and obstetrics, with offices in the La Salle Building.

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The Ramsey County Medical Society has announced the return from military service of the following members:

Dr. Walter D. Brodie, lieutenant commander, in service from May, 1945, to September 27, 1945. Offices in Lowry Medical Arts Building.

Dr. Byron B. Cochran, lieutenant colonel, in service from January 1941, to January, 1946. At Miller Hospital under a University Fellowship in Opthalmology.

Dr. Henry B. Clark, Jr., major, in service from December, 1940, to February, 1946. Offices in Lowry Medical Arts Building.

Dr. Kenneth C. Cook, captain, in service from May, 1942, to June, 1945. Office address, 896 Payne Avenue.

Dr. Robert K. Grau, captain, in service from February, 1942, to November, 1945. Offices at 366 North Prior Avenue.

Dr. Albert F. Hayes, major, in service since February, 1942; terminal leave expires on March 8, 1946. Offices in Lowry Medical Arts Building.

Dr. William W. Heck, major, in service from October, 1942, to October, 1945. Offices in Lowry Medical Arts Building.

Dr. R. W. Marks, captain, in service from November, 1941, to December, 1945. Offices at 61½ West Winifred Street.

Dr. J. Lawrence Noble, major, in service from September, 1942, to October, 1945. Offices in the Lowry Medical Arts Building.

Dr. Burton Rosenholtz, lieutenant commander, in

service from January, 1943, to November, 1945. Now resident physician in psychiatry, Bellevue Hospital, New York City.

Dr. C. L. Steinberg, commander, in service since October, 1942. Terminal leave expired in January, 1946. Offices in Lowry Medical Arts Building.

Dr. B. A. Weis, commander, in service from August, 1942, to January, 1946. Offices at 350 St. Peter Street.

UNIVERSITY NEWS

An electron microscope has recently been installed in Millard Hall at the University of Minnesota Medical School. The following are among the investigations which will involve the use of the microscope: the intracellular identification of a viruslike agent responsible for the high percentage of mammary carcinoma in susceptible strains of mice; microscopic examination of bone, dentin and enamel; a study of the nature of virus inclusions in certain diseases such as vaccinia and herpes; studies of the finer details of bacteria with diameters of the order of 0.5 microns.

A gift of $25,000 was made to the Medical School by the Ebin Foundation of Minneapolis in support of five graduate medical fellowships of $1,000 a year, each to be awarded to veterans of World War II immediately.

Dr. J. Arthur Myers, Professor of Preventive Medicine and Public Health, has been elected Editor-in-Chief of the *Journal of the American College of Chest Physicians.*

Dr. Wesley W. Spink, Associate Professor of Medicine, gave the First Annual Newton Evans Lecture in Bacteriology and Pathology at the College of Medical Evangelists on November 29, 1945. His lecture was entitled "Brucellosis: Diagnostic and Therapeutic Considerations."

At the invitation of the Yale Medical Society, Dr. Robert G. Green, Professor of Bacteriology, presented a lecture on "Health and Disease in Wildlife as Exemplified by Tularemia," on January 9. During the period of his three-day visit; he also gave seminars on: "Immunology of the Milk Factor"; "Vitamin B_1 Inactivation by Raw Fish"; and "Cell-Blockade by Modified Distemper Virus."

Dr. Owen H. Wangensteen, Professor of Surgery and Head of the Department, presented a lecture on December 14 before the Alpha Omega Alpha Society at Stanford Medical School, California, entitled "Intestinal Obstructions." On December 15 he presented a lecture before the California Academy of Medicine, San Francisco, entitled "The Ulcer Problem."

Classified Advertising

WANTED—Assistant to general surgeon, with a busy surgical, industrial and general practice in the City of Saint Paul. Salary open. Address D-150, care MINNESOTA MEDICINE.

PHYSICIAN WANTED—Opening for eye, ear, nose and throat man in group practice. State all qualifications. Write D-152, care MINNESOTA MEDICINE.

FOR RENT—Doctor's office on good business corner, finest residence section in Minneapolis. Established 17 years. Rental $37.50. Address 3717 17th Avenue South, Minneapolis 7, Minn. Telephone: Drexel 5197.

FOR SALE—Westinghouse 100 M.A. X-Ray; automatic built-in Bucky table. All new equipment, used one year. This outfit is A-No. 1. Southern Minnesota. Address D-147, care MINNESOTA MEDICINE.

EXPERIENCED LABORATORY TECHNICIAN desires position in doctor's office, clinic or hospital, Twin Cities. Address D-148, care MINNESOTA MEDICINE.

FOR SALE—General practice in small country town, Northern Minnesota, with large rural area. Unopposed. Municipal hospital, well equipped. Excellent income. Reasonable. Terms, or will hire man at liberal salary. Please give particulars in first letter. Address D-149, care MINNESOTA MEDICINE.

PRACTICE FOR SALE—Active general practice in town of 550 in North Central Minnesota, with house-office combination completely modern, grossing $15,000.00 cash yearly. Excellent nearby hospital facilities. Prefer sale house-office cash or terms. Purchase of drugs and equipment optional. Address D-151, care MINNESOTA MEDICINE.

PHYSICIAN'S OFFICE FOR RENT—Excellent location for general practitioner in a new modern building at 620 Fourth Street, White Bear Lake, Minnesota. Large reception room is shared with dentist who has very good practice. Telephone Emerson 5363, Saint Paul, Minnesota.

SITUATION WANTED—By registered nurse, with experience in bookkeeping, typing, industrial nursing, and clinic work. Can also drive car. Must be in Saint Paul, Minnesota. Telephone: HUmboldt 2909.

BOOK REVIEWS

Books listed here become the property of the Ramsey, Hennepin and St. Louis County Medical Libraries when reviewed. Members, however, are urged to write reviews of any or every recent book which may be of interest to physicians.

MEN WITHOUT GUNS. Text by DeWitt Mackenzie, War Analyst of the Associated Press; descriptive captions by Major Clarence Worden, Medical Department of the United States Army; foreword by Major General Norman T. Kirk, Surgeon General, United States Army. 152 pages. Illustrated, including 118 plates in full color by famous contemporary artists. Price $5.00, cloth. Philadelphia: Blakiston Co., 1945.

CHARTER OF SUGGESTED SCHOOL POLICIES. Published by the Health Education Council, 10 Downing St., New York. Obtainable through Teachers' College, Bureau of Publications, Columbia University, New York, Price $0.25.

Devised as a guide to show how schools and communities can devise balanced programs of health education and health care in schools, this document represents the combined viewpoints of fifteen national organizations concerned with school health. It contains many valuable suggestions for those concerned with the health and nutrition of school children.

PEDIATRIC X-RAY DIAGNOSIS. John Caffey, M.D., Associate Professor of Pediatrics, Columbia University. 838 pages. Illus. Price $12.50. Chicago: Year Book Publishers, 1945.

If one were to say that this book fills a definite need, he would be correct in so doing, because it is an excellent work on diagnostic roentgenology rather than on the roentgenology of pediatrics alone, as the title states. With the exception of the roentgen diagnosis of degenerative diseases, pregnancy, gynecology, and oncology, Caffey's "Pediatrics X-Ray Diagnosis" treats most of the subjects encountered in general diagnostic roentgenology in an admirable manner.

The text is divided into various sections, such as the head and neck, the abdomen and gastro-intestinal tract, et cetera. The sections on the extremities and spine, which make up one-third of the book alone, make it worth while to anyone interested in these fields of medicine. The thoracic section constituting one-fourth of the book is invaluable to the pediatrician, cardiologist and, of course, the roentgenologist and general practitioner.

Controversial subjects of roentgenology, such as the matter of the diagnosis of appendicitis by x-ray and the thymus question, are treated with positive finality, a spirit which pervades the entire work. The limits of roentgen diagnosis are not underemphasized. The pathological terminology is unusually good.

The make-up of the book is exceptionally good, the illustrations are clear, and the diagrams informative. Typographically, it is very easy to read.

The outstanding features are two in number: (1) the rational approach to roentgenology based on embryology, anatomy and pathology, and (2) the numerous "pearls" of incidental information found in the work. The book is modern but does not seem to be dated and can be recommended to anyone who is ever in the familiar situation of deducing diagnostic information from a roentgenogram.

LEO A. NASH, M.D.

REPORTS AND ANNOUNCEMENTS

(Continued from Page 80)

WASHINGTON COUNTY SOCIETY

The annual meeting of the Washington County Medical Society was held December 11, 1945. Aside from the election of officers for 1946, an interesting discussion of health preserving activities in our schools was held.

The meeting was graced by the presence of two members just released from service, Captain George McC. Ruggles, M.D., of Forest Lake and Captain Russell E. Carlson, M.D., of Stillwater.

Major William W. Moir, M.D., is now serving a residency in the Wisconsin General Hospital at Madison, Wisconsin. That leaves only one member still in the service, Commander Samson, M.D., who is expected to be released at an early date.

W. R. Humphrey, M.D., who is vacationing in his native state, Virginia, took time to attend the meeting of the International College of Surgeons in Washington. He is expected home sometime soon.